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Medical Times

The Journal of the
American Medical Profession



Industrial Poisons • Congenital Syphilis
Overlooked Factors in Dyspareunia
Amino Acids • Intestinal Obstruction
Backache • The Father of Geriatrics
The Old Surgeon Muses

Medical Book News

Editorials

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Syntropan has the desirable, antispasmodic actions of belladonna or atropine, but does not depress salivary secretion as actively nor induce mydriasis as readily. When used to induce mydriasis, its influence is not as profound nor as long in duration as that of atropine. The inhibitory action of Syntropan on the parasympathetic innervation of the heart is negligible and not as pronounced as that of atropine. Syntropan has a definite antispasmodic action on spastic smooth muscle, the antispasmodic influence being due jointly to inhibition of the parasympathetic innervation and to direct peripheral relaxing action on the muscle fibers themselves . . . HOFFMANN - LA ROCHE, INC., NUTLEY 10, NEW JERSEY

SYNTROPAN 'ROCHE'—FOR THE RELIEF OF SMOOTH MUSCLE SPASM

EDITORIALS

The More or Less Secret Operation

IT is surprising how many women who have had pelvic operations performed upon them are unable to tell physicians or surgeons consulted later anything about the nature of the operations. Such instances arouse wonder as to how it is that many women submit to such operations without, seemingly, any clear idea as to the whys and wherefores. Do such women lack intelligence or is little or nothing explained to them? To what degree does secrecy tend to prevail? Why should there be any?

Perhaps "there should be a law" requiring operators to furnish their patients with photostatic copies of their hospital records, or at least of their operative records. Secrecy as regards the patient herself is ethically indefensible and it would be absurd to attempt to relate it to the general realm of professional confidences. Moreover, it handicaps the physician and delays the surgeon who may happen to follow after the keeper of secrets.

Dr. William T. Daily has suggested that such data be furnished voluntarily.

Aspirin, Coal-Tar's Favorite Child

PERHAPS more serious than a deficiency of cigarettes, bacon, beef, sugar, chewing gum or whiskey would be a shortage of the coal-tar derivative aspirin. Its abject dependents are legion. According to Bernard Shaw, Lloyd George fought the concluding years of World War I on aspirin. If the little Welsh lion had to depend on aspirin, how can lesser folk be expected to do without it? Its acceptance as an indispensable tool of our civilization is reflected in the lay and medical press, in the drama, and in our literature. We are committed to the sacred rite of eating this drug. Its prestige is greater than that of tea and coffee



and beer combined. If aspirin were ever to fail us we might lose a war some day. We have no doubt that on our present miraculous production line aspirin out-paces all. It is fitting that it should command all priorities. It may be that a mere drug may win a war; it may be the most potent auxiliary of armies and navies and outclass bombs. Could execu-

tives and workers meet administrative and war-plant headaches without this gift of the gods? Indisputable fuehrer in the world of drugs, because of its universality, it overshadows such lesser breeds as penicillin and the sulfonamides.

—From the dire consequences of a shortage of Coal-tar's favorite child, *Good Lord, deliver us always.*

Two-Edged Sword

USING cats as experimental animals, Wasserman of the University of Chicgo has shown that alcohol may have some value as a preventive of combat neuroses.

Perhaps the serving of grog before battles and sea fights in the old days had some scientific justification.

This subject suggests some dubious inferences, however, with respect to the breakdowns of civil life and the relationship of alcoholism to them as crutch or bludgeon.

The old two-edged sword is evidently again trying to crash the gate into quasi-respectability.

We seem to note a bad smell in the air.

Medicine's Stake in the Successful By-Passing of National Suicide

IN Hugh MacLennan's novel, "Two Solitudes," the following striking passage occurs: "The war had started, nations and perhaps civilizations had slid forward for suicide." Wars today are as dangerous to the victor's life as to the lives of the

defeated nations. A nation commits suicide when the ideology and culture of the hated enemy becomes part of itself. Right now Britain is toying with the Government's White Paper proposals for rigid, authoritarian planning of every phase of its national life. The Britain that may emerge out of this situation will perhaps be a political corpse and the image of an erstwhile Axis State, with the medical profession in a servile status. Consider the dangers implicit in a long occupation of Germany by American units both military and administrative. Can there be such a thing as unconditional victory, leaving cherished national traditions intact?

National suicide, including degradation of the medical profession, must somehow be by-passed.

It will never be through wars that mankind will achieve the kind of intellectual integration and social synthesis that men of good will desire—internationalism in the best sense.

The Hall of Fame

STRANGE to say, no physician is commemorated in the Hall of Fame at New

York University. Morton, of ether anesthesia fame, may be said to represent medicine there, but his study of medicine at Harvard was brief. He may have received honorary degrees from medical schools but he was a dentist and not a physician. However, we will not cavil over the point and will concede one representative of medicine in the fact of Morton's presence. But he must be lonely and something should be done about it, or has medicine produced no one of stature comparable with such recent proposals as Louisa Alcott, author of *Little Women*, and James W. Marshall, discoverer of gold in California? Do we overestimate our medical heroes and their achievements or is there some defect in the public's perspective and in the Hall's procedure? We understand that five physicians have recently been nominated and in that connection wonder whether there is any guaranty against the election of Dr. Cook some fine day! That alleged discoverer of the North Pole was famous enough in a way and after all we are talking about a Hall of Fame.



The New York Institute of Clinical Oral Pathology, Inc.

AN open meeting of the New York Institute of Clinical Oral Pathology will take place at the New York Academy of Medicine, 2 East 103rd Street, New York City, on Monday evening, April 30, 1945, at 8:15 P.M.

There will be a symposium entitled "A Survey of the Antibiotic Problem."

The following outstanding investigators will participate:

Daniel Laszlo, M.D., Mt. Sinai Hospital, New York, N. Y. "The Role of Biotics and Antibiotics in Chemotherapy."

Frank Lamont Meleney, M.D., Associate Professor of Clinical Surgery, College of Physicians and Surgeons, Columbia University, and Director of Laboratory of Surgical Bacteriological Research. "The Problem of Penicillin in Treatment of Mixed Infections."

Leo Stern, D.D.S., Mt. Sinai Hospital, New York, N. Y. "The Treatment of Acute and Chronic Infections of the Jaws

with Antibiotics."

Kenneth M. Kahn, Lt. Col. MC,AUS, Chief of Section for Otolaryngology, Haloran General Hospital, Staten Island, New York. "The Relative Value of Antibiotics in the Treatment of Otolaryngic Diseases."

Louis I. Grossman, D.D.S., Associate in Oral Medicine, and Head of Root Therapy Clinic. "Evaluation of Antibiotic Agents for Root Canal Treatment."

Ludwig von Sallmann, M.D., Department of Ophthalmology of the College of Physicians and Surgeons, Columbia University, N. Y. "The Role of Iontophoresis in Ocular Therapy with Antibiotics."

Alvin E. Strock, Senior Assistant Dental Surgeon (R), U. S. Public Health Service Hospital, Manhattan Beach, Brooklyn, N. Y. "Treatment of Ulcerative Stomatitis (Vincent's Infection) with Penicillin."

For further information address all communications to the Executive Secretary, G. Roistacher, 101 East 79th Street, New York 21.

INDUSTRIAL POISONS, ANTIDOTES AND TREATMENTS

Geoffrey Lapage, M.D., M.A., M.Sc.
Cambridge University, England

EVERY doctor should know something about the dangers to which industrial workers are frequently exposed. Many of the substances used in industry are poisonous, and new substances are constantly being produced whose poisonous properties may not be realised even by the chemists who produce them.

Their effects on the human body differ according to how they enter it. Inorganic lead causes anaemia, intestinal colic and chronic inflammation of the peripheral nerves; while organic lead in the form of tetra-ethyl lead blended with petrol is soluble in fats and enters the body through the fatty secretions of the skin, causing insomnia, restlessness and even delirium and mania.

The addition of a nitroso or nitro-group to compounds belonging to the coal-tar derivatives usually increases their poisonous properties, while sulphonation renders them harmless. The physical properties of all chemicals used in industry are also important; the doctor should know whether they vaporize easily or not, so that he can estimate better the risks of breathing them in with the respired air; whether they are liable to enter through the skin because they are soluble in the fatty skin secretions; or whether they are used as dusts which can be swallowed or taken into the lungs.

The doctor should also be able to find out whether the workpeople have suffered in the past from illnesses which render them especially liable to poisoning. Workers with a history of liver disease or kidney trouble should not, for example, work with carbon tetrachloride.

Young people are more liable to accidents, and some people are what is called "accident-prone" though their liability to accidents can be, to some extent, predicted by psychological tests. Ventilation, heating and lighting of the works may all influence the number of accidents.

ONE of the difficulties of the works doctor is that the chemist produces new industrial substances more rapidly than it is possible to investigate their poisonous properties. This is especially

true of the coal-tar derivatives. Much British research is being done in this field. The risks of poisoning by the aromatic hydrocarbon and coal-tar product, benzene, are, for example, being studied.

Benzene—which must be carefully distinguished from benzine, a distillate of petroleum—is dangerous because it permanently damages the bone marrow. British medical men are urging that it should not be used as a solvent. As a rubber solvent in aircraft factories, where it is used almost exclusively by women, as a constituent of quick-drying lacquers, it has led to poisoning by inhalation; for its volatility is high. Poisoning is, nevertheless, rarely fatal and proper ventilation, periodical rests from the work and the exclusion of certain people who are especially susceptible to it, may be sufficient precautions.

Among other poisonous coal-tar derivatives are the aromatic amino-and-nitro-compounds used in the manufacture of explosives and aniline dyes (nitro-benzene, dinitrobenzene, T.N.T., aniline and similar substances). These may convert the red coloring matter of the blood, haemoglobin, into another compound which cannot carry oxygen. People poisoned by these compounds suffer from lack of oxygen and may acquire a bluish or lilac color of the cheeks, ears, tip of the nose and finger nails.

British workers nowadays in contact with T.N.T. are under constant medical care. Taken in through the mouth in the form of a dust, or when the fumes are inhaled, it may cause stomach troubles, jaundice and anaemia; or, contact with the skin may cause troubles which are not serious, but result in much loss of production.

Machine filling of shells and other containers may reduce this form of skin trouble, but is not a complete safeguard. Workers should be medically examined every three weeks or so, and those who have had skin troubles, stomach affections, anaemia, jaundice or kidney disease should be excluded from the work. The worker with hard, horny hands and the colored worker are less likely to suffer from skin troubles due to contact with T.N.T., tetryl and fulminate of mercury.

SKIN troubles will disappear if there is no infection with bacteria, which causes boils, fissures and pustules persisting for months or years. The bright red tetryl rash usually begins on the face and there is swelling around the eyes and intense irritation; the hands and face are stained yellow. T.N.T. rash usually begins on the hands and spreads to the arms, neck and feet; with this also the hands are stained yellow and the condition tends to relapse. In both these affections large areas of the skin may peel off. Scratching should be prevented and the sufferer should be removed from contact with the explosive. Other rules should ensure good ventilation, cleanliness and exclusion of people liable to skin troubles. Periodical medical examinations will detect the first signs of the affection.

Among these aromatic compounds tri-ortho-cresyl phosphate has some importance. In 1930 in the United States it found its way into a drink and caused the poisoning of some 15,000 people; in Durban in 1937 its presence in a cooking oil poisoned many who used this oil. Recently German workers were poisoned by its presence in a fat substitute which they took home from their factory in Munster. It is also used in the plastics industry; it is both an external irritant and a poison to the system. It may cause symptoms resembling those of infantile paralysis, due to inflammation of the nerves. After some gastric trouble the sufferer may notice no effects for 12 days, when a paralysis of the calf muscles of the leg and of the hands occurs, which may last for 18 months or three years or longer.

ANOTHER series of poisonous compounds much used as refrigerants, degreasers of metals, fire extinguishers, cleaners of textiles, solvents of rubber, diluters of cellulose lacquers and so on are the chlorinated hydrocarbons. These are not inflammable, combustible or explosive, but many are liver poisons. Among them are some anaesthetics, such as chloroform and trichlorethylene (trilene). People working with the chlorinated hydrocarbons should avoid anaesthetics of this kind.

Workers with a history of jaundice, gallstones and other liver troubles and malaria, should not handle these substances. One of them is methyl chloride, which is used in the dye industry and is replacing ammonia and sulphur dioxide

as a refrigerant; poisoning by it can be controlled by adequate ventilation. Substances which, like this, contain the organic radical "methyl," seem to have a selective action on the central nervous system. Examples are methyl bromide, used as a fire extinguisher, methyl iodide and methyl alcohol (methanol).

Another chlorinated hydrocarbon the action of which has been much studied is carbon tetrachloride. It has been described as the least harmful of the chlorinated hydrocarbons, but one British investigation of the effects of exposure to the vapor of it under wartime blackout conditions revealed that, during a period of two-and-a-half years, more than half the workers concerned had been discharged or sent to other work because they had been poisoned by it. The symptoms produced were mostly mental or gastro-intestinal and they soon disappeared when the workers were removed from the factories.

Carbon tetrachloride causes liver damage, which is, however, quickly repaired, and poisoning due to it should be adequately controlled by proper ventilation and periodical rests from the work. It was formerly used for the treatment of human hookworm, but has now been largely superseded for this purpose by tetrachlorethylene. Carbon tetrachloride is also used as a rubber solvent, a fire extinguisher and a degreaser and it is an ingredient in some dry shampoos and household cleaners.

Another chlorinated hydrocarbon, tetrachlorethane, has been described as the most dangerous of all members of this chemical series. Its use in the water-proofing of aeroplane wings has been forbidden in Britain since 1917. It is also used in the manufacture of non-inflammable cinema film, artificial silk and pearls, safety glass and as a fire extinguisher, as a solvent for lacquers, waxes and resins and in the fur industry. It causes either gastro-intestinal troubles or nervous symptoms.

Trichlorethylene (trilene) is used as a degreaser and has many uses in dry cleaning and dyeing and textile manufacture and as a rubber solvent. It is less likely than some other chlorinated hydrocarbons to attack the liver and kidneys, but during this war acute poisoning by it has occurred, mostly in connection with metal engraving. It used to be a frequent cause of poisoning in the dry cleaning trade. Its use as an anaesthetic in closed circuits, in which it was able to react with the

soda-lime present in the apparatus used, so that dichloroacetylene was formed, has resulted in palsies of the cranial nerves and other symptoms in the patient anesthetized by it. This problem has been studied at the London Hospital.

FINALLY there are certain skin troubles to which industrial workers are exposed. Ulceration of the skin due to the action of brine, soda, chrome and the bichromates may occur. Caustic soda burns are now treated by irrigation with 5 per cent solution of ammonium chloride instead of by the bicarbonate of soda formerly used, which did not prevent the burn from going deeper. If the burn is irrigated with this ammonium chloride solution within 30-40 seconds of its infliction it will be prevented; in any event irrigation for five minutes will greatly lessen its effects. The burn must be irrigated and not merely dipped into the ammonium chloride and it is essential to wash it for one hour at least afterwards in warm boric saline or water. Burns of the eye should be treated by irrigation with the ammonium chloride solution, followed by irrigation for one hour with warm, boric saline.

Chrome is another of the skin irritants used in industry. It has never been known to cause cancer of the skin and the sufferer from chrome ulceration often goes on working after his ulcers have been dressed. Another group of conditions arises from the irritation caused by machine-cutting oils and paraffin baths used for degreasing and cleaning engine

parts. The oils soluble in water which are used for engine cooling give less trouble than the lard and paraffin oils.

Lard oil may contain some 60 per cent of mineral oil. These oils block the glands and hair follicles of the skin and cause a dermatitis. They should not be used by employees who have a history of skin troubles. The workers should be educated in personal cleanliness and splash guards on the machines should be provided; they should be waisted high in order to prevent oiling of the overalls and consequent irritation due to the friction of these.

For protection against water-soluble oil an alkaline wash containing chlorinated lime, bicarbonate of soda and boric acid is used; for paraffin oil a wash containing soap, glycerine and sodium silicate is useful. The oils should be changed often and analysed. One outbreak of dermatitis due to oils was traced to contamination of the oil with cresylic acid. Any dermatitis that occurs can be treated with soap and water, followed by a 1 per cent solution of gentian violet and a lotion containing calamine or ichthyol, or with zinc and ichthyol cream. For oil acne a neutral sulphonated castor oil in a 2 per cent wetting agent has been very successfully used in Britain and the United States. Dermatitis may also be caused by certain resin glues containing formaldehyde, and by casein glues containing alkalis. A soap containing 5 per cent sodium sulphite, which removes the formaldehyde, and an acid liquid soap containing 15 per cent of fatty acids are recommended for these conditions.



Salmon Lecture Series for 1945

DR. C. CHARLES BURLINGAME, Chairman of the Salmon Memorial Committee, has announced the selection of Dr. Roy Graham Hoskins as the Salmon Memorial Lecturer for 1945. Dr. Hoskins, Research Associate in Physiology, Harvard Medical School, Director, the Memorial Foundation for Neuro-Endocrine Research, Boston, Mass., and Director, Worcester State Hospital, Worcester,

Mass., has, for some eighteen years, devoted much of his time to research concerning endocrine disturbances in mental disease. He is internationally known for his contributions to both the neuro-endocrinological and physiological fields. "The Biology of Schizophrenia" will be the title of the Salmon Lecture Series to be given at the Academy of Medicine, 2 East 103rd Street, on three successive Friday evenings—November 2nd, 9th and 16th, at 8:30 P.M.

OVERLOOKED FACTORS IN THE PATHOGENESIS AND TREATMENT OF DYSPAREUNIA

Wallace Marshall, M.D.
Mobile, Alabama

THE term dyspareunia implies unsatisfactory or difficult coitus and is often applied to painful intercourse (1). It is said to be related to vaginismus, which is a spasm of the vaginal musculature. Hence, vaginismus, or vaginal muscular spasm, can produce painful intercourse, or dyspareunia.

Curtis (2) asserts that painful coitus may be due, many times, to leukorrhea and associated vulvovaginal inflammation. Pressure upon the cervix may give rise to intense pain "because it disturbs a cellular exudate or sensitive uterosacral ligaments."

Pullen (3) calls attention to the majority of such patients which, according to this author, fall into the "psychic group," where "no cause for the dyspareunia can be found."

Many causes for dyspareunia can be found in the literature. Some are listed as: a shortened vagina, cervical infections, too large a penis, prolapse or other abnormalities of the uterine ligaments, lacerations or scars of the vaginal vault, tumors of the female tract, organic stenosis of the vagina, gonorrhea, pudic neuritis, cystitis, hemorrhoids (chronic passive congestion), coccygodynia, fissure in ano, and the like (4).

A complete history, in many cases, may elicit a long-standing history of dyspareunia. In most instances, the patient feels ashamed and does not wish to dwell upon this difficulty. But she welcomes immediate help, since marital relations have usually become abhorrent to her and she realizes most fully that these painful episodes will continue unless help is forthcoming from her physician.

IN most cases which we have investigated, the patients have the libido, but submission to the act has produced disgust because of pain. Very few wives, if any, will inform their partner of this difficulty. Most have agreed that they consummated the act so that their secret would not be known. However, they did

all admit that they tried various ruses to avoid submission. Very few husbands realized that such a difficulty existed in their wives. When informed of the facts in each case, they were highly surprised but were greatly concerned over the prognosis.

From a didactic viewpoint, the subject of dyspareunia can be divided into two categories. The first type of cases are those where a definite lesion is found to exist. (See the examples previously listed.)

The fundamental physical defect, which the author has met by far the most frequently, has been that of endocervicitis. Various stages of this syndrome have been discovered. However, when coitus became actually painful in these cases, cervical ulceration and inflammation were markedly evident to examination with the vaginal speculum. Marked vaginal and cervical discharges were always evident. This one symptom was present so often, that finally this investigator was able to ascertain the presence of dyspareunia by mentioning this probability to the patient.

In order to determine the actual cause of this endocervicitis, vaginal and cervical smears were made on all cases. Surprisingly enough, many cases showed the presence of intestinal types of bacteria. Hence, some reason for this contamination must have taken place in such cases.

After ruling out every conceivable reason for this, we came to the conclusion that the toilet habits of these cases must be at fault. In order to test this theory, we inquired as to the exact manner in which each patient cleansed herself. All agreed, according to our well-founded suspicions, that they rubbed the paper back and forth from the rectum to the vagina, etc. Not one patient stated that she wiped down from the vagina to the rectum and then discarded the paper in order to avoid contamination before using another supply.

Treatment

THIS consisted mainly of two separate categories. The first, of course, was

at the avoidance of future contamination. We took adequate time to explain, with the aid of illustrations, the necessity of the proper use of toilet paper. We stressed the proximity of the rectum to the vaginal orifice, and we explained how contamination took place.

The second phase of our treatment was not difficult. When an ulcerated cervix was encountered, electrocauterization was performed thoroughly at the pathological site. We then gave each patient an applicator and a tube of a vaginocervical cream* which was to be used each evening until further orders discontinued its use. This cream contained allantoin 2 per cent, sulfanilamide 15 per cent, and 5 per cent lactose in a special greaseless base buffered to a pH of 4.5 with lactic acid. The results were completely satisfactory, and most cases were able to be discharged from the office in two weeks' time. The painful coitus ceased with the electrocauterization, and post-cauterization treatment with the cream, although we advised against contact for at least a week following discharge from treatment.

THE other type of case, which we found to be less common, was the psychological type of difficulty. In these patients, we found no endocervicitis, yet the symptom of dyspareunia bothered the patient. Neither did we find evidence of a vaginal discharge.

In order to determine the cause for this disorder, we found that most of these patients were not married for a very long time. In each instance, they seemed to follow a typical pattern which invariably consisted of an intelligent youngster with an exceptionally fine religious family background. At times, the author felt this may have been too good, since many patients were shocked at what went on after marriage. They admitted, with much chagrin, that their mothers never warned them as to just what to expect. Nor did they have any idea as to what they, as wives, were expected to do. These patients agreed that they possessed few, if any, ideas, much less knowledge, as to sexual relations. They confided that they had been taught and had it impressed upon them that the advances of the male species were to be avoided. Once in a

while, the religious aspect became mixed up in their pre-marriage concepts, which certainly did not help matters.

Then, too, when they submitted to their husbands, they could not forget what their family had taught them previously. They were convinced that such goings on were very naughty and should not take place. We found it exceedingly difficult to impress upon them the idea that intercourse is a perfectly natural reaction to those in wedlock. Yet their former family teachings were most difficult to forget, and certainly caused actual resentment toward their parents in some cases, for which I can't blame these youngsters.

Here we have another case where the education of adults may do much good in such matters. It seems to be a very cruel matter to withhold this much needed information from our children, so that, when they marry, they realize that much important information is wanting.

IF any reader wishes to have a real "headache," it can be obtained by advising proper sexual information for the benefit of our youngsters, for I am sure that then one may have to face much criticism and other tribulation at the hands of certain groups which will battle such "communistic" reforms to the bitter end, and one who enjoys life and happiness will do well to shun such an endeavor unless he has an army and navy on his side.

If the physician will take an adequate amount of time with these cases, in order to explain why the patient suffers an emotional upheaval, hence dyspareunia, much progress will be made to overcome this problem. Most patients are very grateful to the physician for this information, and the disorder is usually forgotten in the course of time.

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1. Curtis, A. H.: Textbook of Gynecology. W. B. Saunders Co., 1931, page 320.
2. Curtis, A. H.: Ibid.
3. Pullen, R. L.: Medical Diagnosis. W. B. Saunders Co., Philadelphia and London, 1944, page 609.
4. Yater, W. M.: Symptom Diagnosis. Appleton-Century Co., New York and London, 4th edition; pages 594-5.

SUITE 416 VAN ANTWERP BUILDING.

* Allantomide Vaginal Cream with applicator, manufactured and supplied for this study by The National Drug Company, Philadelphia, Pa.

CASE REPORTS

CONGENITAL SYPHILIS IN PREMATURE TWINS TREATED WITH PENICILLIN

Paul L. Parrish, M.D.
Brooklyn, N. Y.

SYPHILIS is always interesting. The inherited form is of most interest to the pediatricist.

It is a very important disease but I believe that its incidence is greatly overestimated by our government health officials. When I was in charge of the children at Kings County Hospital thousands of serological tests were made. Its incidence in the whites was about 1 per cent, in the blacks about 10 per cent. These children were from the poorest class of society.

Case Report

G. A., colored, aged 20 years, entered St. John's Hospital June 17, 1944, where she delivered twins at about the 8th month of gestation. At birth, aside from rather small size, they showed no recognizable sign of disease but both twins and the mother had a plus 4 Wassermann reaction. They were discharged July 9, 1944.

Previous history: The mother had one child four years before at Greenpoint Hospital. It died of an unknown cause. At that time the mother was positive and had 8 doses of bismuth at the prenatal clinic. At St. John's prenatal clinic the mother had several injections of bismuth. Birth weight of children was—baby A, 4 lb., 9 oz.—baby B, 5 lb., 2 oz.

They entered the Pediatric Department Oct. 11, 1944, at which time each weighed about 8 lbs. There was complaint of a cold and of thrush. These were present. Examination revealed snuffles, slight general glandular enlargement, severe anemia, enlarged liver and spleen, bone changes and slight fibrosis of the lungs. All of which together with the plus Wassermann indicated a severe inherited syphilis.

We decided to try and cure them with penicillin. It was thought best to give them a rather small continuous dose rather than a few larger doses. Each

child was given 1000 units every three hours eight times a day for a month. In that time each received about 250,000 units. Both were improved. At this time A showed plus 4 and B negative. A was given 250,000 more units. They were then allowed to go home. They returned Jan. 18, 1945. Both had continued to gain weight but both showed snuffles and a condylomatous eruption on the buttocks. Baby A showed a large spleen. There was definite improvement in the bones of each. Wassermann, Hinton and Klein were negative in each; Kahn was positive in each.

Neither at any time showed any local irritation or infection from the many injections. For a few days early in the treatment each showed a papular rash, which cleared promptly. Each developed an upper respiratory infection for a few days which caused some loss of weight.

Fig. 1.

Twins A, Female, showing periosteal elevation and destruction of the articular surface at the lower end of the humerus.



Read at the scientific session of the Associated Physicians of Long Island held January 27, 1945, at St. John's Hospital, Brooklyn, N. Y.

THERE are several interesting factors in these cases. One, the insufficient treatment in the prenatal department of two good hospitals. Two, the fact that they were not identical twins, one being a male, the other a female. Three, one was more seriously infected than the other and did not respond as well to treatment. Four, the dose and method of giving. Three hours is about the time the drug remains in the system in sufficient quantity to be of value. One child received the drug every 3 hours for one month, the other for two months. Considering the dose by weight one received the equivalent of about 5,000,000 units and the other twice as much as in an adult man.

There are few reports in the literature of the treatment of new born infants with penicillin. There is an article in a December number of the *J.A.M.A.* Stokes reports 9 cases in his new book.



Fig. 2. Twin A, showing periosteal improvement 2 months later.

I think it is fair to say that these cases were improved, but, in such cases, that penicillin is in no sense a specific. I believe that syphilis of the newborn is more successfully and much less expensively treated by preparations of arsenic or bismuth. My own best results have been with a product called thio-bismol, but I have had severe reactions. I am glad to show you the twins and the x-rays of their bones.

52 SOUTH PORTLAND AVENUE.

OBSERVATIONS ON THE USE OF AMINO ACIDS IN THE TREATMENT OF CERTAIN DISEASES

William F. Kessler, M.D.
Brooklyn, N. Y.

I DON'T wish to pad this paper with a lot of statistical and experimental work that has generally been accepted by most investigators, and which can be verified by a host of articles and standard works. Nor do I wish to state as bald facts my few observations during the past year to the extent that you may carry home with you the idea that we have discovered an "Elixir of Life." I do, however, want to impress upon you this one idea—I believe we have in amino acids an adjunct to therapy and diet, a new form of supple-

mentary medication that will aid us in combatting a few therapeutic problems.

Too often, we physicians are confounded with the problem of curing the patient's symptoms. If our problem were limited to prognosis or curing the patient's diseases, our task would be much easier. But then, if our problem were that simple, the patient would have little reason to consult a regular physician and our job would be that much less attractive. Edema is one of these perplexing symptoms, signs and problems.

ABOUT one year ago I was exposed to a rather erudite discussion of amino acids, and their relation to surgical problems. During the delivery of this topic the physiology and pathological physiology

Read before the Associated Physicians of Long Island at St. John's Hospital, Brooklyn, January 27th, 1945.

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of proteins were discussed. It was established that amino acids played a significant role in some surgical diseases—chiefly burns and postoperative debility. I reasoned that internal medicine was something more than a minor branch of surgery, and if surgical problems could be benefited by recourse to simple medicines, then medical problems could be solved by other than surgical procedures. And don't forget, it was not many years ago that edema could not be treated surgically. Multiple punctures was one method—and accumulations of fluid in serous cavities are still surgically removed by tapping.

I was rather stimulated by this talk and decided to review protein metabolism with the idea in mind of applying amino acid therapy to non-surgical conditions. I did. I had forgotten, in a few years, that the human economy could not synthesize proteins from basic elements; that all cellular tissues required protein for maintenance and survival; that proteins lost from the body must be made up in increased ingestion of protein; that growth required protein and more protein—in other words, I rediscovered proteins for myself.

In order to evaluate protein deficiency it was necessary for the laboratory to offer the clinician some procedure which was not too inaccurate nor too laborious to perform. Now, the average laboratory is capable of doing serum protein estimations with albumin and globulin fractions. This test does not differentiate for us the cause of edema. The history and physical examination do that. But in a few instances there have been confused pictures such as one patient I recall who was a known hypertensive with renal damage who, because of poor finances, developed a nutritional edema. I had no opportunity to follow this patient because he was transferred to a hospital for incurable diseases for a carcinoma of the prostate with metastasis. But if in the course of your examination of a patient it be suggested that protein deficiency might be the cause of the symptoms and signs, the laboratory is a great aid.

I WOULD like to review a few cases and let you be the judge.

Mrs. Q. was referred to me about a year ago for diarrhea and edema following pregnancy and pneumonitis. This was a chronic affair and the patient was steadily losing ground. Hospitalization was ad-

vised and the significant laboratory findings were anemia and low serum protein with a reversal of the A-G ratio. Appropriate treatment was instituted to control her diarrhea and correct her anemia. She was put on a high protein, high vitamin diet supplemented with vitamins and amino acids. In a few weeks there was remarkable improvement. I doubt very much if her serum protein was returned to a normal level with our so-called high protein diet.

Mr. B. had cirrhosis of the liver. And by the way, we could spend a full hour talking about this patient, because he has made such remarkable progress, as have several other cases that we were fortunate to treat. Our main concern with this patient was ascites. He had been tapped three or four times. In the course of our treatment for his cirrhosis we thought that we should "spike" his high protein diet with amino acids. I like to think that he was benefited because his case parallels another cirrhotic who needed many more taps and required much longer hospitalization. We used this patient's own ascitic fluid intravenously in an attempt to raise his serum protein. I would like you to see Mr. B, not as a triumph of amino acids, but as a triumph of many therapeutic agents over cirrhosis of the liver.

Miss A. R. is a young woman of about twenty-six years of age. She has had chronic valvular rheumatic heart disease for many years. Her heart is enlarged and she has double mitral and aortic lesions. In addition she has a liver which is about four fingers below the costal margin. She had been hospitalized for two months and during that period she had been digitalized and was comparatively comfortable on limited activity. But Angelina was concerned not with her heart, nor with her liver. Angelina was concerned with her ankles. They were swollen. In spite of diuresis, salt restriction and limited fluid intake, Angelina's ankles were swollen. Blood studies showed a serum protein on the low side of normal. Merely because we had nothing else to offer her, we gave her amino acids. Soon after, her ankles were nice and slim. She has been home over six months on the same dosage of digitalis that she had in the hospital and certainly with less supervision than she had in the hospital, and she has no ankle edema. She says the amino acid is the only thing that keeps

her ankles from swelling.

Of course, there is the other side. Mrs. S. is an old hypertensive who is not concerned with the size of her ankles as much as she is concerned with the size of her family. I am only consulted in dire emergencies. On one such occasion I suggested she take amino acids to help her swollen legs. She refused any laboratory work-up for fear "they might find something wrong with me." She called me ten days later to tell me her swelling was mostly gone. She neglected to tell me then that she had to "take to bed with severe lumbago which was so bad she had to put a plaster on it," and that she had spent the greater part of a week in bed. I found that out a month later when she called to tell me my medicine was no good, tasted awful, and her legs were just as swollen as ever.

R. S., a young married woman with a small baby and a husband in the army, had a severe colitis and extensive edema. She was given, in addition to other medicines, amino acids because we found a low serum protein. Her edema subsided but her diarrhea didn't clear up until she changed her physician and her husband was discharged from the army.

Mr. C. was hospitalized for several months. He, too, had a low serum protein, marked edema and a large liver. Originally he had had auricular fibrillation which was returned to normal rhythm with digitalis, but never to a slow rate. Amino acids had no effect whatsoever on him. His edema would be slightly and only transiently benefited by intravenous mercurials. At postmortem his liver, although large from passive congestion, was probably atrophic. This raises the question whether or not amino acids can actually damage liver cells, just as a sustained hyperglycemia can damage islet

tissue in the pancreas. It seems reasonable to assume that a severely damaged liver when called upon to exert itself will react like any other overstrained tissue.

IN only two patients who were given amino acids, blood studies showed a rise in the nonprotein nitrogen to over one hundred, yet the creatinine was normal.

Unfortunately, we don't have bedsores at St. John's Hospital. I'd like to try amino acids on them. It has been reported that they are benefited.

I purposely failed to mention preoperative or postoperative care of patients because of limited time. But I wish to mention two cases done here recently. Both had extensive surgery done in the right upper quadrant; both patients were poor risks because of age and their disease; both patients were adequately prepared for surgery; and both patients received amino acids. In passing I might say both patients did well. I don't know if amino acids, or vitamin K or glucose or blood or just good surgery was the reason for their ultimate outcome or whether it was a combination of all factors; I do know they survived.

IN conclusion, I'd like again to remind you how vital protein is to the human economy; that amino acids are the intermediate chemicals between ingested protein and human protein; that we have in amino acids an additional member of our therapeutic family. Of course, it's not as brilliant a child as penicillin nor as versatile and successful as that brood of sulfa drug youngsters, but in a few cases it can do what these other infants can't do, namely, raise serum protein. And by the gods, you don't need red points!

50 PLAZA STREET.

INTESTINAL OBSTRUCTION DUE TO GALLSTONES

Paul H. Sullivan, M.D.

Great Neck, N. Y.

THE following case of intestinal obstruction due to gallstones is presented due to its relative rarity and because of its interesting history. In a review of the cases of intestinal obstruction in the last

Read before the Nassau Surgical Society, March 2, 1945.

5 years at Nassau Hospital there was a total of 113 cases; of these, 7 cases were due to intussusception, 41 to adhesions, 12 to peritonitis from a great variety of causes, 7 to hernia, 21 to carcinoma, 5 to volvulus, 2 to diverticulitis, 1 to mesenteric cyst, 1 granulosis cyst, 1 wound disruption, 1 diaphragmatic hernia, 1 paralytic ileus, 1 endometriosis, 1 regional ileitis. There were 3 proven cases, besides

the one which I report, which were due to gallstones causing an intestinal obstruction. The first case occurred in 1940; a stone was impacted in the jejunum. The second case in 1941; the stone was impacted in the terminal ileum. In the third case, also in 1941, the stone was impacted in the ileum, location not specified. During this period, there were also 2 cases which had a provisional diagnosis of intestinal obstruction due to stones, one of which was operated and no stone was found; the other which was signed out as a case of obstruction due to impacted stone in which neither x-ray, operation nor autopsy was used to verify this diagnosis.

THE present case is that of M. C., a white female, aged 75, who was admitted to Nassau Hospital on November 19, 1944. Her chief complaint was that of acute onset of upper abdominal pain followed by nausea and vomiting which occurred on 11/17/44.

Present illness was that the patient claimed that on the evening of 11/17/44 she was taken with an acute onset of epigastric pain which was soon accompanied by nausea and vomiting. The pain was stated to have been experienced in the epigastric region and did not radiate. At this time the patient thought she was suffering from indigestion. She went out that evening and claimed that her complaints were still present. She applied a hot water bag but the pain became worse. Throughout the evening and the following morning, the patient had repeated episodes of vomiting. The pain never left and it was described as being constant. Everything taken by mouth was vomited. The following day she was seen by me at which time she appeared to be in no severe pain; there was no distention present and abdominal examination revealed no tenderness nor localizing sign. She was given a hypodermic of sodium luminal, 2 grains, and advised to take small amounts of fluid only by mouth. The following morning she was seen and claimed that the pain was still present and that she had been vomiting continuously. Hospitalization was advised.

Past history: Approximately 30 years ago patient had a uterine suspension performed at which time the appendix was also removed. About 22 years ago the patient was in a hospital under observation and, after a careful check-up, she was

told she had gallbladder disease. At time of admission patient claimed that fried and greasy foods caused what she termed "indigestion" and that after meals she felt bloated. She claimed to pass quite a bit of gas per mouth and rectum. She occasionally experienced mild pain in the right subcostal area. She had had an uneventful menopause. No other facts of medical or surgical significance were elicited.

Family history: Her husband died of kidney disease. The remaining members of the family were apparently well.

PHYSICAL EXAMINATION on admission showed an elderly white female complaining of epigastric pain and repeated episodes of vomiting. Patient appeared to be acutely ill but was conscious and appeared to be well-oriented, responding to questions intelligently and cooperatively. *Head*—negative. *Eyes*—pupils were round, regular and equal, reacting to light sluggishly; no nystagmus nor strabismus; color of conjunctiva was good and the sclera showed no icterus. Ophthalmoscopic examination revealed mild retinal sclerosis. *Ears* were negative. *Nose*—negative. *Throat*—lips and tongue were dry; tongue slightly coated; teeth were false, upper and lower dentures; pharynx clear. *Neck*—thyroid not palpable; no nuchal rigidity; no adenopathy. *Chest*—expansion equal. *Heart*—border of dullness outside the mid-clavicular line; apex impulse not localized; sounds were somewhat distant; regular sinus rhythm; A_2 was somewhat accentuated. There was 1-2 plus radial sclerosis. B.P. 156/90. *Lungs* were clear to percussion and auscultation. No rales. Breasts were pendulous; no masses were noted; no discharge from the nipples. *Abdomen*—no distention was noted on admission. There was some vague epigastric and right and left subcostal tenderness; no masses could be outlined; the umbilicus was negative. Inguinal areas were negative. Bladder was not distended. There was an old midline scar which was well healed; no hernia was present. *Extremities* were negative. Reflexes were equal and active. *Rectal examination* was negative. *Vaginal examination*—fundus was small; there were no masses or tenderness on palpation.

Following admission to the hospital, the patient was on intravenous fluids and was given sips of water, tea and ginger

ale by mouth. Early the next morning, the patient vomited a large amount of brownish, fecal-smelling material and when seen early that morning her abdomen was definitely distended and somewhat tympanitic and there was a suggestion of a mass in the right lower quadrant. A flat plate of the abdomen was ordered which showed marked dilatation of several loops of small intestine. There was no gas noticed in the colon or lower small intestine and the findings were those of a complete high intestinal obstruction. *Blood count* upon admission showed a hemoglobin of 96 per cent; red count of 4,800,000; white count of 15,300 with 66 per cent polys, 28 per cent small lymphs, 6 per cent monocytes. *Urinalysis* was negative except for a very faint trace of albumin and a few hyaline and finely and coarsely granular casts.

THE patient was placed on Wangenstein drainage and was given more intravenous fluids. The water balance was adjusted by Dr. Ponder. Twenty-four hours following patient's admission, she was taken to the operating room and under spinal anesthesia was prepared for operation, a diagnosis of intestinal obstruction due to gallstones being made because of the long history of gallbladder disease. Just prior to operation, patient was seen in consultation with Dr. McCartney who agreed with the diagnosis of intestinal obstruction, but, because of the history of the old operation, believed her obstruction probably due to adhesions. A right rectus incision was made and the peritoneum was opened. On opening the peritoneum, a large amount of free fluid was noted as well as several tremendously dilated loops of small bowel. Upon exploring the abdomen with the hand, a mass was noted high in the jejunum and this was brought into the incision and was noted to be a gangrenous portion of high jejunum which contained a gallstone the size of a plum. A longitudinal incision was made after the application of rubber-sheathed clamps above and below the area and the stone was removed. Due to the fact that there was a gangrenous area of small gut in this region, a wedge-shaped piece of small bowel about one inch in length was removed. An end-to-end anastomosis was performed by means of an open anastomosis. The lumen appeared to be adequate. Sulfanilamide powder was placed in the abdomen and a

drain without gauze was placed in the gutter. The incision was closed in layers in the usual manner. Following operation, the patient's vomiting ceased, distention became much less; patient was continued on Wangenstein drainage for 24 hours and, following this, was allowed small amounts of water by mouth. Following operation, patient's temperature, which had been normal, rose to 101; pulse ran between 70 and 80. On the fourth postoperative day, patient was placed on a soft diet and appeared to be doing well. Patient was allowed out of bed on the second postoperative day and this was continued until the sixth day. On the seventh postoperative day, the patient ran a low grade temperature at which time the dressing was changed; there was some redness about the suture line and a small amount of serous drainage was expressed from the lower pole of the incision after removal of one suture. Patient was placed on sulfadiazine at this time and her temperature fell to 99.6. However, following this, the patient continued to drain a small amount of serous drainage and ran a low-grade temperature of about 99. The patient was receiving a Meulengracht diet, and except for the fact that the urinary output was on the low side, she appeared to be doing very well. On 12/10/44 patient had been out of bed for three days and it was decided that she should be discharged on the following day. On the morning of 12/11/44 patient complained that she did not feel well; she had some vague epigastric distress and soon after this complained of slight pain in the left shoulder. When she was examined there were no physical findings to explain the pain but it was decided to leave the patient at bed-rest that day. In the afternoon at about 1:30 the patient suddenly broke out in a cold sweat and became very pale; it was impossible to obtain the patient's blood pressure at this time; she was given 1/6 gr. of morphine and appeared to rally, the pulse coming back and the patient appearing to respond to treatment. About 20 minutes later, the patient suddenly became pulseless, vomited some undigested food and complained of a severe pain over the anterior chest; respirations became extremely stertorous and the patient expired within one-half hour of the onset of her symptoms. A diagnosis of pulmonary embolus was made and an autopsy was obtained.

AT AUTOPSY the following findings were noted: The *abdomen* showed the presence of a recent right rectus incision, the central portion of which was gaping. The subcutaneous fat was hemorrhagic and covered with a small amount of thin serosanguineous fluid. The lower abdomen showed an old healed midline incision. On making the usual Y-shaped incision, the panniculus was found markedly increased in amount. On opening the abdomen, the great omentum and transverse colon were seen to be firmly adherent to the under side of the recent surgical incision. On exploring the surgical incision itself, the walls were hemorrhagic. In addition, a portion of small intestine was seen to be firmly adherent to the anterior wall in the region of the incision. The peritoneal cavity was free from fluid. The intestinal coils were collapsed. The great omentum showed an excess of adipose tissue. The lower jejunum was the seat of a healed side-to-side anastomosis showing, in addition, the presence of a small tunneled sinus tract which led toward the anterior abdominal wall in the region of the recent surgical incision. The terminal ileum lay deep in the pelvis and was firmly adherent to the posterior wall of the uterus and the brim of the pelvis itself. The liver was slightly larger than normal. The capsule was smooth and mottled red and brown in appearance. The area normally occupied by the gallbladder was the seat of a retracted fibrotic mass which fixed the second portion of the duodenum to the under surface of the liver. On section of the second portion of the duodenum, a large fistulous opening leading directly into the fibrotic gallbladder was seen. The fistula admitted the tip of the forefinger readily. The duodenum and the rest of the stomach were natural. The lung showed hyperventilation of the anterior margin, more especially in the upper lobe. The lower lobe

showed minimal atelectasis, more especially in the lateral and posterior aspects. The middle lobe on section was congested. The upper lobe showed congested and edematous surfaces, more especially in the posterior half. The bronchi contained a small amount of mucoid material. The pulmonary arteries on the right side showed no evidence of thrombosis. The left lung in its lower lobe on the lateral and posterior aspect showed a large, hemorrhagic consolidated area with peripheral hemorrhage. The area was slightly firmer than normal. The pulmonary artery on the left showed a large coiled embolus; the embolus was readily removed from the lumen. On further sectioning of the artery distal to the area of embolization, the lumen was seen to contain a lightly adherent currant jelly thrombus.

Anatomical and microscopic summary was:

Lungs: Pulmonary embolus—left pulmonary artery; early recent hemorrhagic infarction—left lower lobe.

Gallbladder: Chronic atrophic and fibrotic cholecystitis with cholecystoduodenal fistula.

G. I. Tract: Recent side-to-side jejunal anastomosis with associated intestinal fistula.

WE have thus seen a case of intestinal obstruction due to an enlarged gallstone which had eroded from the gallbladder into the duodenum and had passed to a portion of the small bowel where it obstructed. The early signs of obstruction which followed were laid to an attack of cholecystitis and operation was delayed until definite gangrene of the small bowel occurred. The patient apparently made a good recovery from the surgical procedure, but, despite the fact that she had been allowed out of bed soon after the operation, she developed a pulmonary embolus and expired.

THAT BACKACHE AGAIN

E. Van Brunt Vurgason, M.D.

Baldwin, N. Y.

IT is not my intention to discuss backache from an orthopedic standpoint. I do not consider myself qualified to do so,

Read before the Nassau Surgical Society March 12, 1945.

and moreover, my fear of bone-crushing reprisals is of considerable magnitude.

However, we have heard much about back pain and suffice it to say that there is much more to be told. There is a great deal of theory about certain forms of backache which calls for more concrete investigation and elucidation so that we

MEDICAL TIMES, MAY, 1945

who see these conditions can understand them and their treatment. Two prominent members of the Nassau Surgical Society, Doctors Hettesheimer and Hudson, wrote, a few years ago, a paper which has helped considerably in understanding one very confusing and misunderstood form of back pain. I refer to causalgic backache.

This paper concerns a very interesting case of pain in the back, treated over a period of seven years before the actual cause was determined and relieved. Five different physicians had previously treated this patient over this period and each one had treated her for just backache apparently, whatever their mental reservations may have been. One advised hot packs, two used diathermy, another used salicylates, and still another told her she was going through her change and should expect to have such pains during this time. He recommended treatments to control her menopausal symptoms.

Now, in considering the question of backache, we must ask ourselves two questions: does the pain originate in the intrinsic structures of the back, such as the bone, joints, muscle, fascia, nerves or a combination of some of these; or does it emanate from some structure or organ outside of the elements of the back itself, such as heart, lungs, pleura, liver and its appendages, stomach or duodenum and their ulcers, spleen, kidneys, appendix, female pelvic organs, prostate, rectum, retroperitoneal tumors, aneurysm, and others. Once this is determined—and believe me, therein lies the great difficulty, and sometimes the greatest difficulty—then can we proceed to further analyze the case, draw our conclusions, and finally treat the patient satisfactorily—we hope.

AND now the case. A 42-year-old, 185-pound, married woman with one pregnancy 21 years ago, with no serious illnesses or operations, other than a pyelitis two years after her pregnancy which was treated and said to have been cured. No complaints until seven years ago when she began to have pain in the "small" of her back on the right side which would last sometimes for days, often radiating laterally to the flank. The pain in this area was not precipitated by lifting or movement. However, the patient stated that at times there was pain in the lower back corresponding to the right sacro-iliac region which did occur occasionally when

she was bowling or housecleaning. She did not recall that the pains occurred simultaneously, but seemed independent of each other. They were both on the same side, one apparently in the costovertebral and the other in the sacro-iliac region. She recalled that about two years previously, when she had had this upper pain, she had experienced a chill, but that was the only time. There were occasional periods of nocturia and frequency, but only occasionally. None of the five physicians had examined her urine.

On physical examination, briefly, there was some tenderness over the right sacro-iliac region, and none on the left. There was no spasticity of the paravertebral muscles on either side, and no skin tenderness. There was definite tenderness over the right costovertebral region extending laterally to the flank. There was some deep tenderness in the right upper quadrant and questionable tenderness on deep pressure in the right lower quadrant. Pelvic examination was very interesting though confusing. The uterus and adnexa were quite normal. On sweeping the fingers along the right posterior pelvic wall, one butted up against a bony hard elevation, somewhat pointed, fixed, and a bit tender when pressed upon (x-ray revealed an opaque mass). The upper border of this ridge could not be reached. The remainder of the physical examination was normal.

Urine showed 3 leukocytes and 1 clump of pus per HPF., and was otherwise negative.

WBC 18,000 with 79 per cent polys.

There was no temperature elevation.

SHE was operated upon and there was revealed a very much enlarged kidney filled with pus, the latter extending downward into a ureter as dilated as one's finger. Most of the kidney parenchyma was destroyed. The ureter was distended as described right down to the bladder, with almost 6 inches of the lower portion containing a long, thick, continuous calculus.

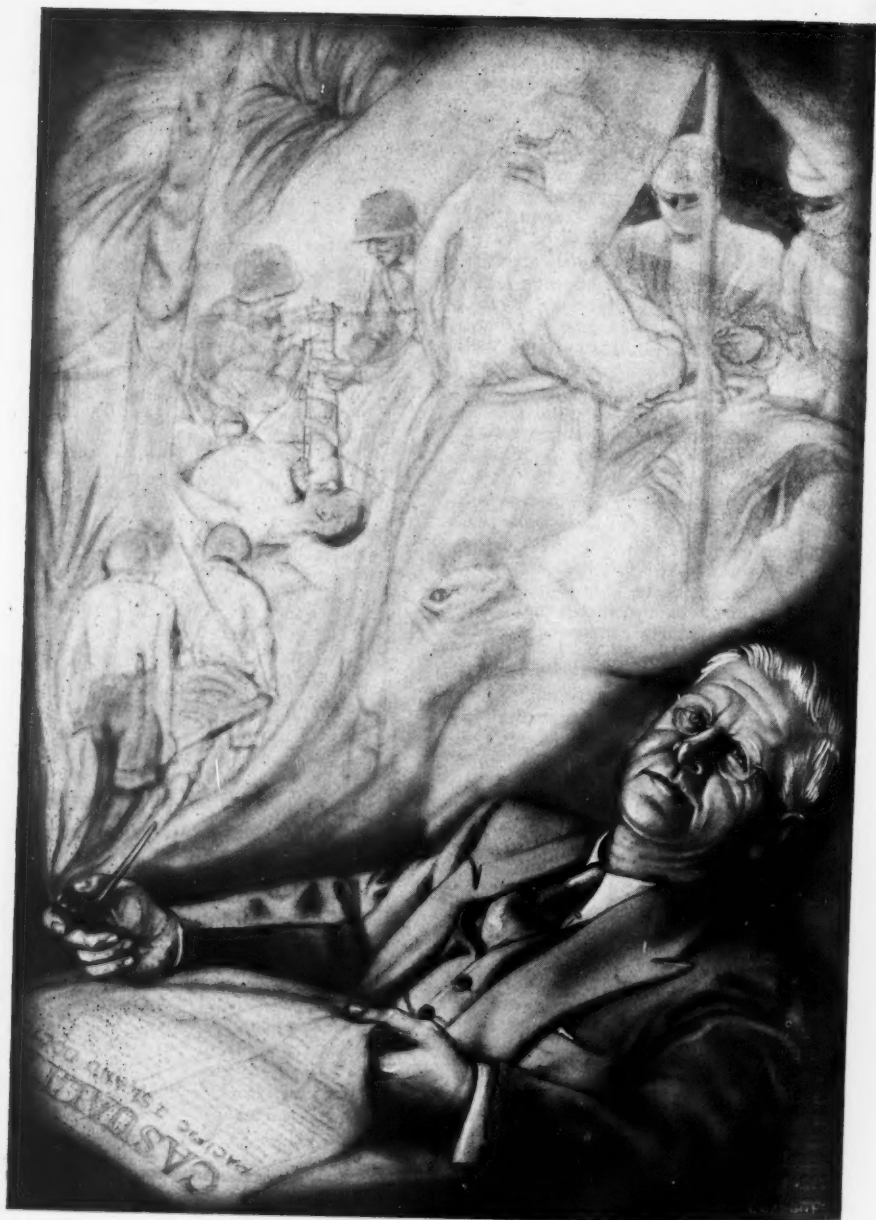
The pathological diagnosis rendered by Dr. Curphey was:

Subacute to chronic pyelonephritis.

Moderately advanced organizing perinephritis.

Acute exudative to chronic organizing ureteritis.

—Concluded on page 139



The Old Surgeon Muses

CULTURAL MEDICINE

THE OLD SURGEON MUSES

PICTURES of the doctor arrived at the evening of life have seemed always to be limited to old general practitioners, usually with long whiskers and very often with an old buggy or horse and saddlebags in the background, seen in a dream, and driven madly through a storm with a stork flying overhead. In this realm old surgeons seem to be forgotten men. So we are making bold in this issue to give the venerable surgeon a break, for even the surgeon frequently exceeds the Biblical limit and then has some visions of his own, too. All our old friends are remarkably bright in eye, and keen of tongue, and none have answered to the elder Henry James's description of Ralph Waldo Emerson in his final years—"like any old woman in a horsecar." There is a quality of life in the old surgeon in keeping with his vital career.

Our illustration of the old surgeon musing represents a phase in his life somewhat later than that expressed by Robert T. Morris in the last chapter of his

book *Fifty Years a Surgeon*. The last phase—sunset—is necessarily one of dreams and fantasies—and yet it is of action that he muses. But before that phase comes we have the intermediate period, or twilight, so well suggested by Morris:

The Long Stillwater

When a man retires from the swift rapids of an active professional life he arrives at a long stillwater, but the banks of that stillwater are so alive, that his days continue to be brimful. Unlike Gibbon who felt desolate upon completing his history, the doctor goes on, for medicine has been collateral to many other interests which were always in the clover field just over the fence. I look forward with almost boyish eagerness to new work and play—time to re-read the old classics and to enjoy choice literature—time to live in the out-of-doors. I shall stalk the moose and bear; not with gun, but with camera. Now I can go when the Red Gods Call.



THAT BACKACHE AGAIN

—Concluded from page 137

Ureteral calculus.
B. proteus in culture.

AND so here is a patient with a history of unrelieved pain in the back, treated over a period of seven years by five different doctors. Now, we all have our failures and our misdiagnoses, and anyone who states differently can be labelled forthwith a mishandler of the truth. For each of these five men this case was one of his failures.

This case strikes me as unusual not only in its pathology, but in the comparison between symptoms and findings. This woman had no fever, no repeated chills, only occasional nocturia and frequency,

no malaise, no colicky pains, no albumin, an occasional pus cell in her urine. She went about her activities in a fairly intense manner, doing her housework, lifting ashes out of the cellar, mowing the lawn, indulging in bowling and other activities, carrying about in her body a kidney three times its normal size, filled with pus, with a ureter as wide as one's finger and a rock in it almost six inches long—and her sole complaint was a pain in the back.

All of the foregoing brings to our attention the folly of treating empirically a pain in the back—or any other pain in the body for that matter—without first seeking its cause, at least as far as our knowledge and facilities, and, let's say, the patient, because that is a factor too, permit us.

44 NORTH MILBURN AVENUE.

IN MEMORIAM

NASCHER—FATHER OF GERIATRICS

Malford W. Thewlis, M.D.

Wakefield, R. I.

IN a world full of chaos, the death of an elderly, retired physician is hardly noticed.

Ignatz Leo Nascher, Father of Geriatrics, died on Christmas Day, 1944, about as inconspicuously as he entered the United States at the age of six months, an emigrant from Vienna, Austria, where he was born on Oct. 11, 1863, son of Adolf and Ernestine (Sternkicht) Nascher. He grew up to be a typical New Yorker and spent his life in that city.

Nascher was a good student in his younger days, educated in New York public schools. He received a Ph. G. degree in 1882 from the New York College of Pharmacy, and later graduated from New York University School of Medicine in 1885. He opened an office on the lower East Side and eventually practiced in nearly every section of New York City.

IFIRST met Nascher in 1915, after writing him a letter expressing my interest in geriatrics, on which he had first written in 1909, having coined the word geriatrics at that time. He later published the first book on this subject in 1914. I went to New York to attend a meeting of the New York Geriatrics Society, which he had founded, that was being held in a school on Columbus Avenue. At that meeting there were several well-known physicians and surgeons—Robert T. Morris, Edward W. Lee, Howard Lilienthal, and Parker Syms. After the meeting, Nascher and I went to the Endicott Hotel and discussed the future of geriatrics until the early hours of the morning. We became friends then, and our friendship lasted until his death. Five hours before he died he wrote me about the subject of a forthcoming paper which was to have been delivered before the American Geriatrics Society in June, 1945.

Nascher's book on geriatrics had been written sometime before it was published. Several publishing houses had declined it. Finally a salesman from Blakiston's be-

came interested in it and sent it to his firm. Blakiston agreed to publish it after some changes in organization. In 1916 a second edition appeared.

Nascher had never been a successful practitioner from the economic standpoint. He was too sympathetic when it came to accepting a fee. I made frequent house visits with him and on many occasions he gave his patients money instead of accepting his fee.

At that time he was chief of Clinics at Mt. Sinai Hospital, out-patient department, New York, where he saw a great many patients each week.

NASCHER delivered the first lectures on geriatrics in this country about 1915 when he became lecturer on geriatrics at Fordham University School of Medicine. He also gave lectures on the same subject at Boston University Medical School.

In 1916 he tired of private practice and accepted a position in the Public Welfare Department of New York, which he held until his retirement (about 1929). He examined nightly many of the 500 guests of the Municipal Lodging House, opposite Bellevue hospital. In 1925 he became chief physician in this department and his work consisted of inspections of hospitals in and around New York City. His sympathies were always with the underprivileged and many acts of kindness unknown to others were performed by him. His book, *The Wretches of Povertyville*, was a sociological study of the Bowery. I doubt if the book can be found today except perhaps in a few libraries.

He knew every niche of New York City, having "explored" the smallest streets and alleys. It was a revelation to go through New York with him on a "personally conducted tour." He was at one time editor of *King's Guide Book of New York*, a guide for those who really wanted to see the city. There were places of interest in it which many people had never heard of.

In later years, Nascher spent much time with one of his hobbies—stamp collecting. But his great hobby was traveling. He



Ignatz Leo Nascher, aet. 80

made 28 trips to Europe, Asia, and South America, "exploring" those countries in much the same manner as he did New York. While in Russia a few years ago he roamed about Moscow without a guide, and since he spoke the language and knew people there he came back with a great deal of information about that country.

When Nascher traveled he usually went without luxury, on the American Export Line. He traveled in foreign countries with very little money. Once he became stranded in Holland, and had not the captain of a certain ship belonged to the same Masonic lodge in New York, Nascher would have had some difficulty in returning. As it stood, he was given passage on the ship.

At the age of 77, he traveled by bus to California and back, rather a tiring journey for a man of his years.

NASCHER'S medical history of the past few years had been a painful one. For months he was ill in Bellevue hospital with peripheral vascular disease. He completely recovered from this and was able to travel again. Fifteen years ago he had his first attack of anginal syndrome. For several years he had an occasional attack but during the past three years the attacks came on at more frequent intervals. He could walk only a short distance without pain yet he traveled to Florida by bus last winter. He had been suffering much pain from herpes zoster for two weeks before his death.

Nascher's bibliography was an extensive one, totaling sixty-one articles in medical journals since his first contribution in 1889. His first article on geriatrics was in 1909 (*Medical Record* 90:1213). From 1909 to 1944 he contributed fifty articles on geriatric subjects. Most of these were between 1909-1929, but after that he wrote an occasional article.

Nascher's mind was as keen at 81 as it was in his younger years. He kept an active interest in geriatrics during these years. When the American Geriatrics Society was formed at Atlantic City in 1942 he was made honorary president. On the second meeting of the society in New York City, in 1944, a meeting dedicated to him, he took an active part and read a paper on *The Aging Mind*. It was a triumph for him to be honored at this meeting. He was preparing for the next meeting and was to discuss *Why Must I Die?*

A KINDER man never lived. He saw a great deal of suffering in this world. He started geriatrics because of a remark he heard in a Vienna institution, during one of his visits there. He was casually told that inmates were suffering from "old age" and "nothing could be done about it." He took exception to the statement and spent a lifetime disproving it.



Our Art Editor Scores

The work of the Art Editor of the *MEDICAL TIMES*, Miss Elizabeth Cuzzort, was well represented in the exhibit of medical artists of national repute which was shown at the Brooklyn Public Library from March 19th to April 14th. Notable

examples of her work occupied a prominent place in the exhibit. The exhibit has been shown in several large cities and we understand is still traveling and drawing large crowds. Twenty-six medical artists active in medical schools, hospitals and clinics are represented in this important educational enterprise.

CONTEMPORARY PROGRESS

MEDICINE

Fractional Gastric Analysis: A Simplified Technic with Interpretation of Results

ALEXANDER RUSH (*Medical Clinics of North America*, Nov. 1944:1516) describes a simplified method of gastric analysis. Nothing is taken by mouth after midnight preceding the test. The stomach is first completely emptied by aspiration with a Levin or Rehfuß tube; the secretion obtained is the "fasting specimen"; 2 or 3 drops of Töpfer's reagent is added to this specimen. If this sample shows a red color with this reagent, the test is discontinued, and the volume and hydrochloric acid content of the fasting specimen are determined. If the sample develops a yellow color with the reagent "an appropriate stimulus" to gastric secretion is injected, and the stomach is completely emptied by aspiration at 45, 60 and 75 minutes after the injection, the volume and hydrochloric acid content of each specimen being determined separately. The stimulus of gastric secretion used may be histamine acid phosphate 0.1 cc. per kg. body weight given subcutaneously or regular insulin 1 unit per kg. body weight given intravenously. Gastric analysis is of some value, "albeit limited," in the diagnosis of certain diseases, especially peptic ulcer, subacute combined degeneration of the spinal cord, uncomplicated atrophic gastritis, atrophy associated with certain types of anemia and gastric carcinoma. In treatment gastric analysis is of value in estimating the extent of alkali therapy and the effectiveness of the methods employed to control gastric acidity. With the test described, if the volume of the fasting contents is over 120 cc., this is an indication of peptic ulcer or pyloric obstruction; and if the free HCl in the fasting specimen is greater than 50 clinical units, this is an indication of peptic ulcer. If there is no

free HCl in any of the specimens after stimulation this indicates an abnormal state, and is compatible with the diagnosis of pernicious anemia, subacute combined degeneration of the spinal cord, sprue, or complicated or uncomplicated atrophic gastritis. The test described gives "the essential information" obtained from any fractional gastric analysis, simplifies the procedure, and definitely shortens the time required.

COMMENT

This test should be done more often. It is a simple office procedure and the author has made the technique an easy one. Perhaps pernicious anemia is too often diagnosed without a gastric analysis.

M.W.T.

Sternal Puncture as a Practical Diagnostic Procedure

S. PROPP and J. L. SCHWIND (*Annals of Internal Medicine*, 21:580, Oct. 1944) describe their method of sternal puncture, which is similar to that described by Arinkin. The needles used are of the 18 gauge spinal puncture type with a stylet and a heavy finger grip; the needle portion varies in length; 2 and 1.5 cm. needles are used for adults and 1 cm. for infants and children. The puncture is made in the midline of the sternum at the level of the third costosternal articulation, or in children, at the level of the third interspace. The skin and underlying structures are infiltrated with novocaine before the puncture is made. The puncture needle is inserted vertically, and given a rotary movement under firm pressure until the outer table of the sternum is pierced. Boring is continued until the needle is firmly fixed in the sternum, a tuberculin syringe is then attached to the needle, and marrow fluid aspirated; if aspiration is not successful on the first attempt, the needle is advanced further until marrow fluid is obtained, 0.1 to 0.2 cc.

being withdrawn. The smears from this marrow fluid are examined promptly, using Wright's stain. In a series of 140 cases, sternal puncture was considered to be clinically indicated in 74 cases; in 65 per cent of these cases, the information obtained by the puncture was of definite clinical value, and a diagnosis was definitely established in 16.2 per cent of cases that was impossible by any other method except biopsy. Diagnosis is made with certainty only when a typical or specific myelogram is present, but in other cases the myelograms may give information of value. Specific myelograms are found in leukemia, especially acute and leukopenic leukemia; in pernicious anemia in relapse; achrestic anemia and sprue (megoblastic marrow); in granulocytosis in the arrested marrow stage; in neoplasms; in lipid histiocytosis, in malaria; and in leishmaniasis.

COMMENT

This is a practical method for performing sternal biopsy, a procedure which should be used more frequently. For the early diagnosis of certain diseases this offers the best method.

M.W.T.

Penicillin with Special Reference to Its Use in Infections Complicating Diabetes

F. B. PECK (*American Journal of Medical Sciences*, 208:581, Nov. 1944) reports 15 cases in which penicillin was employed in the treatment of various infections in diabetics, such as infectious gangrene, osteomyelitis of the bones of the feet, large sloughing carbuncles, and other local infections which so frequently complicate diabetes. There were 3 deaths in this series, none of which could be

attributed to failure of the drug. In one of the fatal cases (a large carbuncle of the neck) the amount of penicillin given was inadequate, owing to scarcity of the drug. In another case of extensive carbuncle, the patient was admitted to the hospital in coma and died the third day after admission. In the third fatal case, the patient had bilateral lobar pneumonia and penicillin treatment was begun only on the eighth day of the disease, on ad-

mission to the hospital; the patient died within a few hours after admission, death being due to sudden cardiac failure. The results in this series of cases indicates that penicillin is of definite value in the management of infections due to susceptible organisms complicating diabetes. Penicillin is effective against gram-positive organisms and gram-negative cocci, but not against gram-negative bacilli; thus it is important to determine the causative organism before penicillin is used. Penicillin is "so nearly non-toxic" that it can be used with safety. In the

cases reported, there was no evidence that penicillin therapy had any deleterious effect on carbohydrate tolerance or necessitated an increase in the insulin dosage; there was no unusual difficulty in the control of the diabetes in any of these cases. Other methods of treatment must not be neglected, especially surgical drainage when indicated. In many of the local infections treated, local injections of penicillin into the infected tissues were more effective than systemic treatment; the solutions used for local therapy ranged from 100 to 1,000 units per cc.

COMMENT

This important contribution should be read

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in its entirety. It brings out several important points regarding the effectiveness of local treatment, combined surgical and penicillin therapy, and the fact that penicillin does not disturb persons with diabetes.

M.W.T.

Rapid Plan for Treatment of Early Syphilis for Office Practice

A. B. CANNON, J. K. FISHER and L. Wexler (*New York State Journal of Medicine*, 44:2571, Dec. 1, 1944) describe a method of intensive treatment of early syphilis that is suitable for office treatment. This plan is based on the methods used in the City Hospital and in the Vanderbilt Clinic. At the City Hospital, all patients were given two injections of mapharsen of 120 mg. each on the first day. Patients of the heavy weight group (165-220 lb.) and of the middle weight group (135-165 lb.) were also given two mapharsen injections on the second day, and the treatment of "the heavy weights" was continued with 120 mg. daily for the remainder of the twelve days. Patients in the middle-weight and light-weight groups continued treatment with 120 mg. daily for the remainder of the first week and 60 mg. daily for the second week. During this course of arsenical treatment, each patient was given 100 mg. of bismuth subsalicylate intramuscularly twice a week. Following this course of treatment, patients were referred to the out-patient clinic for twenty-five weekly injections of bismuth. Under this treatment all lesions healed before the patients were discharged from the hospital. The supplementary course of bismuth treatment was designed to prevent infectious relapses and also to keep the patient under observation. In the Vanderbilt Clinic, daily injections of arsphenamine have been given five days a week, requiring a month for a course of twenty injections. The dosage was based on the weight of the patient; the minimum total dosage was 5.5 gm. for men and 4.95 gm. for women. In some cases daily injections of mapharsen have been given five days a week giving 120 mg. for each of ten injections. The authors have treated 3 patients in their private practice, giving seventeen consecutive treatments, with a total dosage of 5.2 gm. arsphenamine. All these patients were working throughout the treatment and had no reaction to the drug. The authors'

experience has convinced them that better results are obtained by combining bismuth with the arsenical than with the arsenical alone, and also by continuing bismuth after the arsenical course is completed. For office practice they suggest for intensive treatment a twelve weeks' course of treatment, six daily injections of 120 mg. mapharsen the first week (omitting Sunday) and six daily injections of 60 mg. mapharsen the second week, combined with 1 cc. bismuth salicylate in oil (10 per cent) twice weekly. This is followed by four weeks' treatment with bismuth (2 cc. once a week). The seventh and eighth week, the course with mapharsen and bismuth is repeated, then bismuth 2 cc. weekly is continued for four more weeks. Bismuth (2 cc. weekly) should be given for four or five months following this course of treatment. In cases where this intensive plan cannot be carried out, a less intensive plan covering twenty weeks is outlined. With this plan the mapharsen injections are given three times a week (alternate days); the first week 120 mg. are given at each injection, subsequently 60 mg.; 1 cc. bismuth salicylate in oil is given twice weekly with the arsenical. The arsenical combined with bismuth is given the first four weeks, the 9th through the 12th week and the 17th through the 20th week of the course. In the interval 2 cc. of the bismuth salicylate are given weekly. The authors have found that the best results are obtained by giving a large dose of the arsenical on beginning treatment, and then diminishing the dosage. This may increase the incidence of reactions on the first day, but such reactions are usually not severe, and as treatment is continued few reactions occur. If a patient with early syphilis disappears from treatment even after the first course of the arsenical in the intensive plan of treatment, he still has "a quick spirochetal sterilization and a better than 50 per cent chance of being cured."

COMMENT

This effective system of treatment should be filed in the physician's card index system. The physician can follow this plan in office treatment since most patients are anxious to hasten the treatment of syphilis.

M.W.T.

MEDICAL TIMES, MAY, 1945

SURGERY

Skin Graft Fixation by Plasma-Thrombin Adhesion

FORREST YOUNG (*Annals of Surgery*, 120:450, Oct. 1944) describes a method for skin graft fixation by the use of thrombin and plasma. This method may be used with any type of skin graft, but in the cases reported, it was employed with split-thickness grafts. If the wound to be grafted is a fresh surgical wound, hemostasis is secured; in traumatic fresh wounds, dead and devitalized tissue is removed and the "accepted principles of wound care" followed. If a granulating area is to be grafted, moist saline dressings, frequently changed, are employed to prepare the area; or if infection is marked, azochloramid, Dakin's solution or sulfa film. The granulations are cut or scraped down to a firm base at the time of operation before the grafts are applied. The area to be grafted is then "flushed" with plasma. The grafts are not placed in saline or washed, but the under-surface of the graft is wet with thrombin solution. The graft is quickly spread over the "bed," and held firmly and smoothly in place for two minutes. In the cases reported no compression dressings have been used. In some cases splinting has been employed; in others a loose dry gauze has been employed for protection. This method has been used in 22 cases. In 8 cases in which free grafts were placed on fresh surgical wounds, all grafts took 100 per cent. In 4 cases in which grafts were placed on fresh traumatic wounds, the percentage of takes was 48 per cent; this percentage is lowered because the graft was totally lost in one instance. In 10 granulating wounds a 59 per cent average take was obtained; in 2 of these cases the graft was lost completely. The author concludes that this method of fixing grafts is useful for grafting fresh surgical wounds, for applying small grafts where compression dressings are not ordinarily used, and for holding larger grafts while compression dressings are applied.

COMMENT

The surgical principles necessary to insure success in skin grafting are very well defined and universally accepted. Ingenious and clever techniques have been elaborated and described. The specialist in plastic surgery has a great

deal to offer and each year his successful accomplishments earn the gratitude of an increasing number of patients and the acclaim of his confreres.

Young has met the difficulty of fixing and maintaining the graft in position by using plasma and thrombin. The results obtained are enthusiastically set forth. They are indeed convincing enough to warrant further trial and study of this method.

T.M.B.

A Technique of Aseptic or Closed Gastric Resection Using the Furniss Clamp

L. C. CULLIGAN (*Surgery, Gynecology and Obstetrics*, 79:629, Dec. 1944) describes a technique for aseptic gastric resection using the Furniss clamp. The Furniss clamp has previously been used in closure of the duodenal stump and in aseptic surgery of the bowel. Its application to gastric resection is the new feature of the author's technique. The stomach wall is completely denuded of mesentery about $\frac{1}{4}$ inch above the line where the Furniss clamp is to be placed. The clamp with handles curved upward is applied obliquely across the stomach and screwed tightly into place so as to crush the stomach wall firmly. A Payr clamp is then applied about $\frac{1}{4}$ inch distal to the Furniss clamp and the stomach is "cut across" with the electro-cautery knife, leaving a short "cuff" of stomach wall protruding beyond the Furniss clamp. The mucous membrane of the cuff is scraped out, and the remainder is thoroughly "cooked" with the actual cautery. The long Furniss needle is then pushed through the clamp and the clamp removed. The cut edges of the stomach are inspected and any bleeding is controlled by electro-coagulation or by ligation of the bleeding vessel. The Hofmeister type of anastomosis has been employed, as it has been found that the Furniss clamp and needle can be used to advantage with this type of anastomosis. In making the anastomosis the stomach is rotated so that obstruction of the proximal loop is prevented where it is joined to the lesser curvature of the stomach; then the distal loop is joined to the greater curvature of the stomach. This method has been used in 46 gastric resections for ulcer with one postoperative death due to jaundice and anuria caused either by a transfusion

or a sulfonamide reaction. The same technique has also been used in 11 gastric resections for carcinoma, with one post-operative death in a "poor risk" patient with mitral stenosis; death was due to the cardiac condition.

COMMENT

Modern surgical advances have made it possible for the surgeon to undertake major operations upon the stomach, not alone in cases of peptic ulcer and its complications but similarly in cases of cancer of the stomach. He does so with increasing confidence, the result of added knowledge, further experience and additional skill. The technic of gastrectomy has been brilliantly and painstakingly developed. It was to be expected that sooner or later some intrepid operator would adapt a closed or aseptic procedure.

Calligan has made use of the Furniss clamp in accomplishing this purpose. His reports include the successful use of the Furniss clamp in 57 resections, 46 for ulcer and 11 for cancer. Now we know "it can be done". His results were highly satisfactory. However, the aseptic technic is hardly a sine qua non in surgery of this type; equally good results have been obtained by others less meticulous about aseptic anastomosis, yet skillful in performing their own type of resection. Other things being equal it would seem that the closed method is not a deciding factor between success and failure. On the other hand, the very fact that so many surgical clinicians are conscientiously tackling these problems in their own original way and setting forth their results in concise reports is bound to raise the standards in gastric surgery, broaden its applicability and augment its beneficial accomplishments.

T.M.B.

Intravenous Anesthesia in Major Surgery

J. K. NARAT and E. GIRALDI (*American Journal of Surgery*, 66:178, Nov. 1944) report the use of intravenous anesthesia in major surgical operations. A 1 per cent solution of pentothal sodium and administration by the drip method are employed. A fairly rapid flow of the solution, 100 to 150 drops per minute, is used to induce anesthesia. As soon as the patient loses consciousness, the jaw is relaxed, respirations become shallow and the eyelid reflex is abolished, the rate of flow is reduced considerably to 4 or 5 drops per minute. The depth of respiration is the chief guide in determining the level of anesthesia and regulating the administration of the pentothal solution. When the patient is asleep, pure oxygen

is given for one minute and then a mixture of equal parts of oxygen and nitrous oxide throughout the operation. If the relaxation is not satisfactory, cyclopropane is used instead of nitrous oxide. In cases in which complete relaxation is not essential, as for a breast amputation, helium is given with the oxygen instead of nitrous oxide. Helium is also given if the patient has "a dusky appearance"; and may be added to the oxygen toward the end of the operation to bring the patient out of deep anesthesia. After the patient has been given approximately 1.5 gm. of pentothal and relaxation is good, but the operation is not completed, enough saline solution is added to "transform" the 1 per cent solution of pentothal into a $\frac{3}{4}$ or even $\frac{1}{4}$ per cent solution. This type of anesthesia has been used in 1,462 consecutive cases including all types of major surgical operations. These cases include patients in shock, those with severe anemia, cardiac decompensation, diabetes, obstructive jaundice and thyrotoxicosis. There have been no serious complications from the anesthetic. The chief contraindication to the use of pentothal sodium intravenously is impaired pulmonary ventilation. The advantages of this type of anesthesia are that it is easily induced with no stage of excitement; and that the incidence of post-anesthetic nausea and vomiting is greatly reduced.

COMMENT

The surgeon is still chasing that "will of the wisp," the ideal anesthetic agent. Anesthesiology has come into its own. Never has there been a time when so much is known about so many anesthetic agents. Advantages and disadvantages, dangers and pitfalls, availability and performance—all are carefully weighed and evaluated. A wide and varied choice is possible. Skillful and competent administration is essential. Certainly the use of intravenous anesthesia in major surgery as set forth in the article abstracted is not foolproof. It presupposes the superlative in technic of administration. Of course it has distinct advantages when properly safeguarded. Its use in 1462 cases without serious complication emphasizes what can be accomplished under the most favorable circumstances of complete control.

A young medical reserve officer returning from a 3 month course at a clinic nationally known voiced his surprise at the very large number of major operations performed under ether anesthesia. This impressed him particu-

larly for at this clinic there was no dearth of competent, well trained and enthusiastic anesthetists.

In the mad search for the ideal anesthetic agent it is best that we keep our feet on the ground and preserve a proper sense of proportion. One cannot deny that compared with the first decade of this century the candidate for operation gets a "real break" in the matter of anesthesia. Who knows what further experience will lead to, before the end of the century?

T.M.B.

Recent Experiences with Penicillin in the Treatment of Surgical Infections

F. L. MELENEY (*Bulletin of The New York Academy of Medicine*, 20:517, Oct. 1944) reports results obtained with the use of penicillin in surgical infections in civilian practice by a group of surgeons working in cooperation with the Committee on Chemotherapy and Other Agents of the National Research Council. In the 275 cases reported penicillin was used for general treatment only in 144 cases, for local treatment only in 64 cases, and for combined local and general treatment in 67 cases. The results are classified as excellent when there was an almost immediate response to treatment (within 48 hours); as good, when the benefit was definite, but slower; as questionable, when the case might have progressed as well without penicillin; as "no effect," when the infection "went through its usual course." In the cases receiving general treatment only results were classed as excellent in 38.2 per cent and as good in 27.8 per cent. In the cases receiving local treatment only, results were classed as excellent in 20.3 per cent and as good in 36 per cent. This may be explained by the fact that in the "general" group there were many cases in which the infection was in an early stage, while in the local treatment group, there had been a breakdown of tissue which took time for evacuation or absorption. In the cases with proved septicemia due to hemolytic *Staphylococcus aureus* the response to penicillin therapy was favorable in 73 per cent (excellent in 48 per cent, good in 25 per cent). Penicillin is apparently "meeting a real therapeutic need" in this type of infection, which formerly had a high mortality and does not respond satisfactorily to the sulfonamides. There were only 8 cases of hemolytic streptococcus septicemia, of which 4 (50 per cent) showed a

favorable response to penicillin therapy. The fact that there were so few cases of this type of infection in this series "is itself a triumph for the sulfonamides." In 4 cases of acute osteomyelitis, the response to penicillin therapy was excellent or good in all; but in 39 cases of chronic osteomyelitis, excellent results were obtained in only 6 cases, and good results in 15 cases; this group needs a more detailed analysis to determine the reasons "for success on the one hand and failure on the other." In a small group of 7 cases of gas gangrene favorable results were reported with penicillin therapy in only 3 cases, and in these cases amputation was required, but could be done through, instead of above, the involved tissue. No definite conclusions as to dosage can be drawn from the study of these cases, but from the facts presented, the author considers that it "seems reasonable" in pure staphylococcal infections to give 80,000 to 100,000 units as an initial dose for general treatment; and to double this in mixed infections. Local dosage of less than 10,000 units has given favorable results in well localized infections, but much more study of various factors in local therapy is necessary. A minimum of six days of treatment appears to be advisable. Sixteen illustrative cases are reported.

COMMENT

It has all happened so quickly. The age of miracles in medicine and surgery. Wonder working chemotherapy. First the sulfonamides and now penicillin. In a war-torn world in the midst of deadly conflict, wanton destruction and universal upheaval, a great boon has been conferred upon the human family. No, providence has not abandoned mankind. Here are gifts which in succeeding years will save more lives than have been or will be lost in this war. Penicillin has been made available for civilian use with few or no restrictions. Clinical experience with the use of this drug is developing rapidly. Reputed results are being studied and slowly but surely the successful achievements secured under ideal conditions of control will be duplicated in every community by any doctor who will familiarize himself with the growing literature on this subject.

Dr. Meloney's report of the use of this drug in 275 cases is authoritative and informative.

The reader is impressed with the scientific application to the problems involved. He cannot miss the point that if studies, reports and statistics are to be of any scientific and prac-

tical value they must be collected, set down and presented as they have been in this article under discussion.

T.M.B.

UROLOGY

The Treatment of Stricture of the Urethra with the High Frequency Cutting Current

G. R. LIVERMORE (*Journal of Urology*, 53:462, Nov. 1944) describes his method of treating stricture of the urethra with the high frequency cutting current. He has designed a sound-shaped electrode with a copper strip on its convex surface, through which the current is applied to the stricture. The size and site of the stricture are first determined by passing a bougie à boule; the sound electrode is then introduced until the copper strip on the convex surface is in contact with the stricture. The cutting current is then turned on, and the electrode is passed rapidly back and forth and rotated to apply the current to different areas in the stricture. The strength of the current is No. 4 on one dial and medium at the other of the first Wappler instrument for resection. When the electrode is removed, the "next size" ordinary sound is introduced and left in for five minutes. After ten days, sounds are passed, but the size is not increased after hemorrhage has occurred; the electrode can be used again in two weeks. The author has used this method for several years; he does not claim that it is a cure for stricture, but he has found that the use of the high frequency current, as described, causes strictures to dilate more easily with less pain than with any other method, and that there is less tendency "to recontract" than when only sounds and dilators are used.

COMMENT

In the hands of Professor Livermore this method may be successful but doubt may be expressed as to its advisability in the hands of the rank and file of doctors. Memory goes back to the days when negative galvanism was most successful in relaxing, absorbing (by its fibrolytic action) and expanding strictures, according to the nature of the lesion. In a large

measure negative galvanism (Neumann's method) is one of the best means of treating stricture. Mistakes soon appeared by which positive galvanism was used, which has a caustic effect, making many strictures worse and occasionally causing adhesion of mucosa to the electrode. The Otis urethrotome is a useful instrument but I saw a general surgeon dilate it to its limit and then draw the knife in the deep urethra. He divided the pampiniform plexus. The patient bled to death. To use a high frequency current of the cautery type is certainly a risky procedure. The margin between no cauterization and some cauterization is very narrow. Accidents based on this fact are sure to happen. A stricture is a scar in the urethra which cannot be removed. Hence, common sense must be applied as to how it is treated. The high vacuum glass electrode is a very valuable method of dilating simple strictures because the acinic nature of the current softens the stricture much as negative galvanism does without the slightest likelihood of damage. When I began to apply electrotherapy in urology I was told that I had traveled far afield. I am still of the opinion that whereas I may have traveled others are wandering about in the same field at least somewhat aimlessly.

V.C.P.

Tumors of the Testis; Analysis of Fifty Cases

C. A. HELLWIG (*Urologic and Cutaneous Review*, 48:538, Nov. 1944) reports 50 cases of malignant tumor of the testis found on histologic examination; in the same period 204 non-malignant enlargements of the testis were studied histologically at the same hospital. On the basis of these findings one out of 5 patients submitted to orchiectomy had a malignant tumor of the testis. Of the 50 cases of malignant tumor reported, 27 were solid carcinoma of the seminoma type. Three of these patients showed metastases on admission to the hospital; and all have died. Orchiectomy was done in 24 cases; postoperative radiation was employed in 13 cases, and also preoperative radiation in 2 of these cases. Of the 18 patients that have been followed up, 10 are living

and well, 3 for five years or more. There were 22 cases of adenocarcinoma in the series; 3 of these patients showed palpable metastases on admission and all have died. Orchiectomy was done in all but one of this group, with postoperative radiation in 11 cases and preoperative radiation in one case. Of the 17 patients followed up, 9 are living, but one of these shows metastases to the lungs; 4 are living and well more than five years after treatment (orchiectomy and radiation). In the one case of choriocarcinoma in the series, the symptoms were due to a retroperitoneal metastasis; the tumor was found only by histological examination of the testes, although urinary assay during life had shown 5000 mouse units of Prolan B per cc.; death was due to pulmonary metastases. Aschheim-Zondek tests were made in 21 of these cases; it was found that this test was not always positive in malignant tumor of the testis. However, a high excretion of Prolan A and the presence of any Prolan B were found to indicate an unfavorable prognosis. The author considers that a positive Aschheim-Zondek test is of undoubted value in the diagnosis of malignant tumor of the testis, but a negative test should not be regarded as definitely excluding this diagnosis. In this series of cases, the value of preoperative x-ray treatment was not established; postoperative radiation was found to be of definite benefit, but it increased the five-year survival rate by only 13 per cent as compared with that with orchiectomy alone. The five-year survival rate for the series was 38.9 per cent. The author considers the presence or absence of metastases at the time of operation the most important factor in prognosis.

COMMENT

The tendency is for many tumors of the testis to be malignant sooner or later. Hence early removal without injury of or pressure on the cord is indicated. The presence of metastases is practically a contraindication for the operation. All these patients die. I recall a case in which only a small nodule was present. At operation this nodule was found to be a black mass of malignant neoplasm. I lost sight of the man after many years of good health.

V.C.P.

The Use of Dicoumarol and Vitamin K in Urologic Cases

EMERSON SMITH and JOSEPH

MEDICAL TIMES, MAY, 1945

KAUFMANN (*Journal of Urology*, 53: 353, Oct. 1944) have found both dicoumarol and vitamin K of value in urological conditions. The dosage of dicoumarol usually employed is 5 mg. per kg. body weight given by mouth, and its administration is controlled by daily determinations of the prothrombin time. Dicoumarol has been used prophylactically after operation on the kidney, and in one case before and after the repair of a vesicovaginal fistula in a patient who had phlebitis. Dicoumarol has also been used in cases of inoperable tumors of the kidney or bladder which cause bleeding with clot formation in the bladder; the administration of dicoumarol in such cases until the prothrombin time is maintained at 55 to 70 seconds has prevented the formation of clots. Vitamin K is indicated in cases of painless hematuria in which no definite cause for the bleeding can be found and the prothrombin time is prolonged. In 2 illustrative cases reported the hematuria was completely controlled by the administration of vitamin K until the prothrombin time was brought to 15 to 25 seconds.

COMMENT

Any measure which will limit or control bleeding and clotting is worthy of trial. So many new remedies appear that one is confused if not discouraged. While not exactly on the point (except as to all new remedies), one may say that there are now on the market about 400 barbituric acid preparations all stemming from the discovery that the original one had sleep-producing action. Self-medication is rampant and deaths common.

V.C.P.

Subtotal Perineal Prostatectomy; Presentation of a New Technique

V. G. MARSHALL (*Journal of Urology*, 52:250, Sept. 1944) describes a method of subtotal perineal prostatectomy. The approach used is the same as that described by Young; when the rectal surface of the prostate is exposed, frozen sections are made from any "suspicious areas," and if carcinoma is found Young's radical operation is done. If no carcinoma is demonstrated a subtotal prostatectomy is done. With the technique described, the tissues above and on the anterior commissure are preserved, which avoids damage to the nerve supply of the bladder; the capsule is removed; control of bleeding is obtained by the use of clamp and ligature under

vision; the bladder outlet is constructed so as to resemble the "normal architecture." Following operation the bladder is irrigated in much the same way as following transurethral prostatectomy. The author considers that this operation has definite advantages over perineal enucleation of the prostate; small unrecognized carcinoma will probably be entirely removed by this method. This operation has been used in 18 cases; 5 of these patients had no leakage of urine after the indwelling catheter was removed; and 9 had only slight leaking of urine (when the bladder was full or "on stress"). By three months after operation, 14 had normal control of urine, and 4 only slight leakage; none required a clamp or pad because of lack of control of urine. The postoperative control of urine with this method, therefore, compares favorably with that following other methods of prostatectomy.

COMMENT

This new operation has the merits of conservation of the neck of the bladder and of nerve-supply and repair of the deep field. It is open to challenge on the point that a prostate which requires surgery is usually one which should receive total enucleation. The reason is that when hypertrophy is deeply seated it so remains and continues as true hypertrophy.

V.C.P.

Amicrobial Pyuria

E. N. COOK (*Bulletin of The New York Academy of Medicine*, 20:587, Nov. 1944) emphasizes the fact that in cases of pyuria, it is essential to demonstrate whether or not the infection actually involves the kidneys, ureters or bladder. In women infection of the cervix, and in men prostatic infection is a frequent cause of pyuria, and these infections are not benefited by chemotherapy. It is not necessary for every patient with pyuria to have a complete urologic examination, but if two courses of treatment with mandelic acid or the sulfonamides do not clear the urine, the patient should be given a complete examination. The demonstration of the infecting organism is of importance, and this is done by microscopic examination of the urinary sediment after Gram staining. In the group of cases in which

no organisms are demonstrated by this method, the possibility of tuberculous infection must be considered; stains should be used to identify acid-fast bacilli, and guinea-pig inoculation is also necessary before tuberculosis can be definitely eliminated. In amicrobial pyuria, the symptoms are severe, often more severe than with the usual bacillary or coccal urinary tract infections; dysuria and frequency with tenesmus are the usual symptoms; sometimes there is hematuria; systemic reactions are not common, but have been observed in some cases. The urine is "loaded" with cellular elements and epithelial debris. In the treatment of amicrobial pyuria, the administration of the usual urinary antiseptics is not effective either in relieving the symptoms or reducing the pyuria. Local therapy, with continuous irrigation for vesical lavage, is of some value in relieving severe symptoms, but it is only a palliative measure. In cases in which tuberculosis is excluded, the most effective form of therapy for amicrobial pyuria has been found to be the arsenicals given by injection. In the author's experience, small doses of neoarsphenamine have proved as effective as larger doses. He recommends an initial dose of 0.2 gm., followed by 0.3 gm. at a four or five day interval, and if necessary by subsequent doses of 0.3 gm. at similar intervals. Often the first two doses are sufficient to clear up the condition; occasionally a third or fourth injection may be necessary. This treatment should be supplemented by the removal of any foci of infection. Not only the teeth and the tonsils should be investigated carefully, but the prostate gland in men and the cervix uteri in women should also be considered as possible foci of infection and treatment instituted if infection is found.

COMMENT

It is not easy to accept the statement that pyuria is often strictly amicrobial. Probably in most cases, smear, culture and animal inoculation will decide the question. I recall a case which for many months remained amicrobial. Then, the tubercle bacillus came down in clusters. I regret to admit that in this case I did not have animal inoculation done. In some of these cases, no doubt absorption from a focus such as the prostate or cervix may cause pyuria. Nevertheless animal inoculation and culture will almost always find the organisms which smears miss.

V.C.P.

PEDIATRICS

Experience with Sulfapyrazine in Children

H. N. VANDEGRIFT (*Journal of Pediatrics*, 25:386, Nov. 1944) reports the use of sulfapyrazine in the treatment of various infections in 119 infants and children. In the less severe cases sulfapyrazine was given by mouth. The dosage for infants was 1 grain (0.064 gm.) per pound body weight per twenty-four hours, one-half being given as an initial dose, and the total daily dosage divided into six doses; children over six years of age were given 2 gm. sulfapyrazine initially followed by 0.5 gm. every four hours. Determinations of the concentration of the drug in the blood showed that this was lower than that obtained with other sulfonamides. Doubling the dosage of sulfapyrazine increased the blood level of the drug less than 1 per cent. The drug was, however, therapeutically as effective as other sulfonamides. In 21 cases of severe infection, sulfapyrazine was given intravenously in the form of a 1 per cent solution of sodium sulfapyrazine in a dosage of 1½ grains (0.096 gm.) per pound body weight per twenty-four hours; this gave a high initial concentration of the drug in the blood, but this concentration could be maintained only by repeated intravenous injections at frequent intervals—"an unpractical procedure" in infants and young children; also the high blood levels of the drug produced by intravenous injection increased the danger of renal damage. When patients with moderately severe infection could not retain sulfapyrazine by mouth, it was given by subcutaneous injection, employing a 0.5 per cent solution of sodium sulfapyrazine in normal saline in a dosage of ½ grain per pound body weight every eight hours for twenty-four to forty-eight hours, then continuing until the drug could be given by mouth. The infections treated in this series were the usual ones observed in a children's hospital, including upper respiratory tract infections, otitis media, broncho-pneumonia, meningitis, and diarrhea. The results were similar to those obtained with sulfadiazine. Toxic reactions were few; there was no nausea or vomiting attributable to the drug; no rash or other skin manifestation; and no alteration in

the white or red blood cell count. One patient developed gross hematuria following intravenous administration of sulfapyrazine; 9 patients developed transitory microscopic hematuria. One patient was given sulfapyrazine on two different occasions, and 4 others on two to four occasions without developing any sign of sensitivity. These results indicate that sulfapyrazine is "a drug of high potency and extremely low toxicity," and "an excellent drug" for the treatment of various types of infection in infants and children.

The Fate of Very Young Children with Tuberculosis

G. F. MITCHELL and H. S. WILLIS (*American Review of Tuberculosis*, 50: 316, Oct. 1944) report a study of 243 children admitted to a tuberculosis sanatorium with definite evidence of tuberculosis other than a positive tuberculin reaction. The x-ray examination in these cases showed that tracheobronchial lymph nodes only were involved in 57 cases, the lung parenchyma only in 46 cases, and both tracheobronchial nodes and lung parenchyma in 110 cases. In 30 cases, the disease was of the reinfection type. Eighteen of the 30 children with reinfection tuberculosis died in the hospital, a mortality of 60 per cent. The hospital mortality was higher for Negro children than for white children, with primary or reinfection tuberculosis. Of 90 Negro children, 21, or 23.3 per cent, died in the hospital, while of 153 white children, 16, or 10.5 per cent, died in the hospital. Of the 46 children hospitalized for less than three months, 27 were seriously ill and died in the hospital, mostly within a few days after admission; miliary disease and meningitis "accounted for" 19 of these fatal cases. After this early critical period, the fatality rate lessened rapidly, for, of the 197 children hospitalized for more than three months, only 10 died in the sanatorium, 2 of the deaths being due to non-tuberculosis disease. The fatality rate in the hospital was highest among the younger children (up to nineteen months of age), for 18 of the 37 deaths occurred among 62 children in this age group, a fatality rate of 29 per cent, while 19 deaths occurred among 181 children over eighteen months of age, a fatality rate of

10.5 per cent. Of the 206 children discharged from the hospital, 194 had primary and 12 reinfection tuberculosis. The majority of these children (163) were discharged with the disease "apparently arrested" and had been adequately treated in the sanatorium. There have been only 10 deaths among 160 patients followed up after discharge from the hospital; 3 of these deaths occurred among 15 patients discharged after short hospitalization, and 7 among 145 patients discharged after a longer stay in the hospital; in the latter group, only 2 deaths were proved to be due to tuberculosis. Of 126 patients discharged with the disease "apparently arrested," who have been followed up, only 4 have died (3.2 per cent); 121 of these 126 patients were clinically well at the time of their last follow-up examination. This definitely indicates the advantage of adequate hospital treatment for children with active tuberculosis, with or without symptoms, until the disease is arrested.

A Completely Supplemented Evaporated Milk and Its Use as a Food for Infants

E. V. McCOLLUM and W. GRUBB (*American Journal of Diseases of Children*, 68:231, Oct. 1944) report the use of an evaporated milk supplemented by vitamins and minerals so as to make a complete food for infants. The food as prepared for distribution is a liquid, each can containing 13 fluid ounces. The food is concentrated so that feedings can be adjusted by the degree of dilution. Added calories can be supplied by the addition of carbohydrates in the form of sugar or corn syrup. Of 101 healthy infants up to two months of age who were given this milk, 83 remained under observation for a sufficient length of time to complete their records. The average period of study for the whole group was 5.8 months, the longest period, eight months. The feedings prescribed provided 50 to 60 calories per pound body weight per day; the amount of carbohydrate added varied between 5 and 7 per cent of the total bulk of the formula; the ratio of food to water varied from 1:1 to 1:2. This provided variations to fit the need of the individual infant. The administration of supplementary vitamins was forbidden. All the infants thrived and showed good weight gains on the diet. Even those who showed "unfavorable nutritional features" when first seen, did well. No clinical or

roentgenological signs of vitamin deficiency were observed in any case. Blood and urine analyses also gave no indication of vitamin deficiency. One infant ten months of age with active scurvy was given the test food in the usual quantities for the weight and age, and showed rapid improvement both clinically and roentgenologically. The authors conclude that the supplemented evaporated milk tested is a suitable complete food for infants for at least the first nine months of life. The food as prepared is "well adapted to transportation, storage and distribution." Tests have shown that it remains unchanged for six months, "the average shelf life" of most proprietary products.

The Treatment of Celiac Disease with Vitamin B Complex and Concentrated Liver

D. PATERSON, M. PIERCE and E. PECK (*Archives of Disease in Childhood*, 19:99, Sept. 1944) report the treatment of 26 cases of idiopathic celiac disease and 4 cases of celiac syndrome in children, with intramuscular injections of liver extract and intramuscular injections or oral administration of vitamin B complex. With intramuscular injections of both liver extract and vitamin B complex, patients with idiopathic celiac disease showed satisfactory gain in height and weight and improvement in general health in the early weeks of treatment, which was maintained if treatment was continued for a prolonged period. If the vitamin B complex was given by mouth with parenteral liver extract improvement was "less dramatic," and weight gains were less satisfactory. After the initial weeks of treatment, the children did well on a normal balanced diet. The stool fat diminished in all but 4 of the 26 cases, and returned to normal in 18 cases. In the 4 cases of celiac syndrome resulting from chronic foci of infection, parenteral administration of liver extract and vitamin B complex appeared to hasten improvement. In the cases of idiopathic celiac disease in which vitamin A absorption curves were determined before and during treatment, these curves did not return to normal in any case but improvement was observed in some instances. In cases in which oral glucose tolerance curves were obtained before and during treatment, a return to normal was observed in some instances.

Medical BOOK NEWS



STEPHEN HALES
1677-1761

Classical Quotations

● Experiment I. In December I caused a mare to be tied down alive on her back; . . . having laid open the left crural artery . . . I inserted into it . . . a glass tube, which was 9 feet in length; . . . The blood rose in the tube 8 feet 3 inches perpendicular above the level of the left ventricle of the heart.

STEPHEN HALES

Haemostaticks, 1773.

Soap in Medicine

Medical Uses of Soap. A Symposium. Morris Fishbein, M.D., Editor. Philadelphia, Pa., J. B. Lippincott Co., [c. 1945]. 182 pages, illustrated. 8vo. Cloth, \$3.00.

THIS neatly bound book is a first attempt to rationalize soap from a therapeutic and prophylactic angle. It is written by ten leading specialists including chemists, dermatologists, a mycologist, and research workers, as well as representatives of soap manufacturers. It is intended as a reference book for the entire profession but is especially useful to the dermatologist, syphilologist and public health physician.

This neat volume gives a concise description of modern manufacture and chemistry of soap, and answers many questions as to the effects of soap on the normal skin and hair, on the abnormal skin, on shaving and shampooing, and on the irritations produced by soap under various conditions, but makes little or no mention of the therapeutic effect of soap solution on the mucous membranes, in which the profession is also interested.

On the whole the reviewer strongly recommends this very informative book on this old but always timely topic.

THOMAS B. WOOD

Edited by

ALFRED E. SHIPLEY, M.D., Dr. P.H.

All books for review and communications concerning Book News should be addressed to the Editor of this department, 1313 Bedford Avenue, Brooklyn 16, N. Y.

Educating the Worker

Health Education on the Industrial Front. The 1942 Health Education Conference of the New York Academy of Medicine. New York, Columbia University Press, [c. 1943]. 63 pages. 8vo. Cloth, \$1.25.

THIS small volume contains the presentations of the 1942 Health Education Conference of the New York Academy of Medicine. The articles contained are written by physicians highly trained and specializing in various problems in Industrial Health. Such questions as war-time industrialization of the community, food and nutrition, disease and handicap detection and control, mental problems and morale, educational methods and control of industry are ably presented. To any one dealing with problems in Industrial Medicine this volume of Health Education is highly recommended.

IRVING GRAY

Handbook on Malaria

Malaria: Its Diagnosis, Treatment and Prophylaxis. By Colonel William N. Bisham, M.D., U.S.A., Retired. Baltimore, Williams & Wilkins Co., [c. 1944]. 197 pages, illustrated. 8vo. Cloth, \$3.50.

THIS concise, well-written, up-to-date handbook on malaria, designed expressly for the clinician is remarkably complete in view of its convenient size. Although most attention is naturally given to symptomatology, pathology, diagnosis, treatment and prophylaxis, consideration of the distribution of malaria, the distribution and habits of the important vectors, and epidemiology is by no means neglected. Each of the seventeen chapters has been reviewed, prior to publication, by a distinguished authority on that phase of malariology considered in the chapter in question. There are five excellent plates, four of them in color, illustrating the various stages of the malarial parasites. The occasional typographical error which has escaped the proofreader does not detract from the over-all excellence of a book which should prove valuable to every physician who may encounter malaria in his practice.

E. J. TIFFANY

BOOKS RECEIVED for review are promptly acknowledged in this column; we assume no other obligation in return for the courtesy of those sending us the same. In most cases, review notices will be promptly published shortly after acknowledgment of receipt has been made in this column.

The Etiology, Diagnosis, and Treatment of Amebiasis. By Col. Charles Franklin Craig, U.S.A., Ret., D.S.M. Baltimore, The Williams & Wilkins Co., [c. 1944]. 332 pages, illustrated. 8vo. Cloth, \$4.50.

Annual of Clinical Mycology. Prepared Under the Auspices of the Division of Medical Sciences of the National Research Council. By Norman F. Conant, Ph.D., Donald Stover Martin, M.D., David Tillerson Smith, M.D., Roger Denio Baker, M.D., and Jasper Lamar Callaway, M.D. Philadelphia, W. B. Saunders Company, [c. 1944]. 348 pages, illustrated. 12mo. Cloth, \$3.50.

Modern Ophthalmic Lenses and Optical Glass. By Theo. E. Obrig, A.B. 3rd Edition. New York, [Obrig] [c. 1944]. 323 pages, illustrated. 8vo. Cloth, \$4.50.

Brucellosis En Cuba. By Dr. Francisco Martinez de la Cruz. Camaguey, Cuba, El Camagueyano Co., [c. 1943]. 288 pages. 8vo.

The Avitaminoses. By Walter H. Eddy, Ph.D., and Gilbert Dalldorf, M.D. 3rd Edition. Baltimore, Williams & Wilkins Co., [c. 1944]. 8vo. 438 pages, illustrated. Cloth, \$4.50.

Clinical Heart Disease. By Samuel A. Levine, M.D. 3rd Edition, Revised. Philadelphia, W. B. Saunders Co., [c. 1945]. 8vo. 462 pages, illustrated. Cloth, \$6.00.

Surgery of Modern Warfare. Edited by Hamilton Bailey, F.R.C.S., Sub-Editor for Medicine, C. Allan Birch, M.D. Compiled by Seventy-seven Contributors. Vols. I & II, 3rd Edition. Baltimore, Williams & Wilkins Co., [c. 1944]. 8vo. 1108 pages, illustrated. Cloth, \$20.00 per set.

Medico-Legal Blood Group Determination. Theory Technique Practice. By David Harley, M. D. New York, Grune & Stratton, [c. 1944]. 8vo. 119 pages, illustrated. Cloth, \$3.50.

Freud's Contribution to Psychiatry. By A. A. Brill, M.D. New York, W. W. Norton & Co., Inc., [c. 1944]. 8vo. 244 pages. Cloth, \$2.75.

Patients Have Families. By Henry B. Richardson, M.D. New York, The Commonwealth Fund, [c. 1945]. 8vo. 408 pages. Cloth, \$3.00.

Internal Medicine. Its Theory and Practice. In Contributions by American Authors. Edited by John H. Musser, M.D. 4th Edition, Revised. Philadelphia, Lea & Febiger, [c. 1945]. 4to. 1518 pages, illustrated. Cloth, \$10.00.

Case Studies in the Psychopathology of Crime. A Reference Source for Research in Criminal Material. Vol. 11. By Ben Karpman, M.D. Washington, Medical Science Press, [c. 1944]. 4to. 738 pages. Cloth, \$16.00.

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